American Recovery and Reinvestment Act of 2009,
Division A, Title XIII - Health Information Technology,
Subtitle C—Public Health Service Act (PHSA) Title XXX,
Subtitle B, Section 3011

Beacon Community Cooperative Agreement Program

Funding Opportunity Announcement

and

Application Instructions

Office of the National Coordinator for Health Information Technology

Department of Health and Human Services

2009

Opportunity Overview

Department of Health and Human Services (HHS)

Office of the National Coordinator for Health Information Technology (ONC)

Funding Opportunity Title: ***American Recovery and Reinvestment Act of 2009, Funding to Beacon Communities***

Announcement Type: ***New Competitive Program***

Funding Opportunity Number: HHS-2010-ONC-BC-004

Catalog of Federal Domestic Assistance (CFDA) Number: 93.727

Key Dates and Submission Information: Applicants are required to submit a Letter of Intent to apply for this funding opportunity. Applicants will be required to submit an application that will undergo screening for completeness and responsiveness. Applications that pass this initial screening will then be evaluated through an objective review process. Successful applications will result in the award of approximately fifteen 36-month cooperative agreements. Award decisions for Beacon Communities are anticipated to be made in March 2010.

Approx Funding	FOA Released	Letters of Intent Due	Applications Due	Cooperative Agreements Awarded	Anticipated Start Date
$220 million	December 2, 2009	January 8, 2010 11:59 PM EST BeaconCommunityGrants@hhs.gov	February 1, 2010 5:00 PM EST **http://www.grants.gov**	March 2010	April 1, 2010

Executive Summary

The Beacon Community Cooperative Agreement Program will provide funding to communities to build and strengthen their health information technology (health IT) infrastructure and exchange capabilities to demonstrate the vision of the future where hospitals, clinicians and patients are meaningful users of health IT, and together the community achieves measurable improvements in health care quality, safety, efficiency, and population health. Awards will be made in the form of cooperative agreements to approximately 15 qualified non-profit organizations or government entities representing geographic health care communities. Selected communities must already be national leaders in the advancement of health IT, workflow redesign and care coordination, or quality monitoring and feedback. In addition, successful communities must have advanced rates of electronic health record (EHR) adoption and health information exchange (HIE), and the readiness to incorporate health IT to advance community-level care coordination and quality monitoring and feedback. Cooperative agreement recipients will evolve and advance their existing competencies in these three areas over a 36-month

performance period. Individually and in aggregate, the Beacon Communities will generate and disseminate valuable lessons learned that will be applicable to the rest of the nation's communities as they strive to build and leverage their health IT infrastructure for healthcare improvement. Total funding for this initiative is $220,000,000.

American Recovery and Reinvestment Act of 2009

Beacon Community Program

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Funding Opportunity Description

A. Background

On February 17, 2009, the President signed the American Recovery and Reinvestment Act of 2009 (Recovery Act). Title XIII of Division A and Title IV of Division B of the Recovery Act, together cited as the Health Information Technology for Economic and Clinical Health Act (HITECH Act), include provisions to promote meaningful use of health information technology (health IT) to improve the quality and value of American health care. The HITECH Act also established the Office of the National Coordinator for Health Information Technology (ONC) within the U.S. Department of Health and Human Services (HHS) as the principal federal entity responsible for coordinating the effort to implement a nationwide health IT infrastructure that allows for the use and exchange of health information in electronic format.

Within the HITECH Act are directives enabling Medicare and Medicaid incentive payments for adoption and meaningful use of electronic health records (EHRs), as well as the establishment of the Health Information Technology Regional Extension Center program to facilitate EHR adoption and meaningful use among providers and the creation of the national Health Information Technology Research Center (HITRC) to support these processes. The focus on meaningful use is a recognition that better health care does not come solely from the adoption of technology itself but through the exchange and use of health information to best inform clinical decisions at the point of care. The criteria defining meaningful use, expected to be released in a Notice of Proposed Rulemaking by the Centers for Medicare & Medicaid Services in December 2009, will serve as community-wide metrics for the infrastructure of certified health IT and secure exchange of health information necessary to realize health outcome and system efficiency improvements. Through local, practice- and provider-level support, technical assistance, education, and coordination, the 70 Regional Extension Centers established under HITECH will assist 100,000 providers to achieve meaningful use of EHRs by 2012. The HITRC will analyze and support national efforts to provide technical assistance and develop or recognize best practices to support and accelerate efforts to adopt, implement, and effectively utilize certified EHR technology that allows for the electronic exchange and use of information in compliance with applicable standards, implementation specifications, and certification criteria. Through this coordinated effort to develop and disseminate best practices for adoption and meaningful use of EHRs, the regional centers and HITRC will facilitate national goals for widespread use of EHRs for healthcare improvement.

Empowering local providers to improve the health of their populations through health IT is the first step towards the establishment of an electronically connected, patient-centric healthcare system. Another essential step is to enable the promotion of electronic movement and use of health information between organizations required to improve quality of care and efficiency, and establish an information infrastructure to support health care reform. Section 3013 of the HITECH Act recognizes the critical importance of State and qualified State-designated entities to advance standards-based health information exchange (HIE) and establishes a grant program to provide funding to

States and qualified State-designated entities for planning, capacity building, and implementation activities that will enable health care providers across states to share health information throughout the continuum of care.

Section 3011 of the Public Health Service Act (PHSA) as amended by the Recovery Act (Pub. L 111-5) authorizes immediate funding to strengthen the health information technology infrastructure in the United States. The statute provides for funding to support (1) health information technology architecture that will support the nationwide electronic exchange and use of health information in a secure, private, and accurate manner; (2) development and adoption of appropriate certified electronic health records for categories of health care providers not eligible for incentive payments; (3) training and dissemination of information on best practices to integrate health IT, including EHR, into a provider's delivery of care; (4) infrastructure and tools for the promotion of telemedicine; (5) promotion of interoperability of clinical data repositories or registries; (6) promotion of technologies and best practices that enhance the protection of health information by all holders of individually identifiable health information; and (7) improvement and expansion of the use of health IT by public health departments.

HHS is using the authority provided by section 3011 to award funding to approximately 15 Beacon Communities to support activities that will strengthen the health IT infrastructure both in those communities and ultimately across the United States. The Beacon Communities funded through this program will be expected to invest in the health IT architecture of the community and to engage in the specific activities outlined in the statute in order to develop and strengthen an existing infrastructure of interoperable health IT and standards-based information exchange while also advancing specific health improvement goals declared by each community. This program is anticipated to demonstrate the promise for health IT and provide evidence to providers and other communities that widespread adoption of HIT and exchange of health information is both feasible and improves care delivery and health outcomes. The program will also generate lessons learned on how other communities can achieve meaningful use on a community-wide basis.

For information about additional priority grant programs authorized by the HITECH Act to address critical, short-term prerequisites to achieving the vision of a transformed health system where every American benefits from secure, standards-based interoperable EHRs, see Appendix C.

B. **Purpose**

The Beacon Community grants program will provide funding to communities to demonstrate the vision of the future where hospitals, clinicians, and patients are meaningful users of health information technology (health IT), and together the community achieves measurable improvements in health care quality, safety and efficiency. The program will seek to advance a health IT infrastructure that will support the nationwide electronic exchange and use of health information in a secure, private, and accurate manner. Communities will be expected to build on an existing infrastructure of

interoperable health IT and standards-based information exchange to advance specific health improvement goals declared by each community. This program is anticipated to demonstrate the promise for health IT and provide evidence to providers and other communities that widespread adoption of health IT and exchange of health information is both feasible and improves care delivery and health outcomes. The program will also generate lessons learned on how other communities can achieve meaningful use on a community-wide basis.

The communities will receive funding and/or support from the different agencies with expertise in such goals, such as the Office of the National Coordinator for Health Information Technology, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Centers for Disease Control and Prevention, and the Indian Health Service.

The program will fulfill the Department's statutory obligations under section 3011 of the PHSA, as added by the Recovery Act. Importantly, this program seeks to implement the PHSA section 3011(a) directive that the Secretary shall invest in this infrastructure and promote the electronic exchange and use of health information consistent with the goals of the strategic plan developed by the National Coordinator under section 3001 of the Recovery Act. The section 3001 strategic plan, also known as "The ONC-Coordinated Federal Health IT Strategic Plan: 2008-2012" (dated June 3, 2008), provides as its first goal, *Patient-focused health care.* This goal seeks to "[e]nable the transformation to higher quality, more cost-efficient, patient-focused health care through electronic health information access and use by care providers, and by patients and their designees." The second goal is *Population health,* which seeks to "[e]nable the appropriate, authorized, and timely access and use of electronic health information to benefit public health, biomedical research, quality improvement, and emergency preparedness." Consistent with these goals, the Beacon Community grants program will attempt to demonstrate the feasibility of achieving the objectives related to health care delivery system outcome and efficiency and population health objectives for the meaningful use criteria for HIT incentive payments.

Communities will also demonstrate that care can be coordinated and health information exchanged in a manner that enhances the protection of health information by all holders of individually identifiable health information.

Funds under this program will be directed to strengthen the health IT infrastructure of communities with the capacity and experience to achieve a high level of meaningful use of health IT in order to demonstrate how communities can leverage that infrastructure to advance health outcomes and cost-containment initiatives. Only communities that already have a relatively high level of health IT adoption will be able to achieve high enough levels of meaningful use in the short term to demonstrate the feasibility of cost and quality improvements, and only communities doing so can be expected to attract public- and private-sector funding to sustain their health IT infrastructure. The Beacon Community Program, therefore, will be critical to the Department's efforts to promote the development of a nationwide health information infrastructure built on the sustainable efforts of local providers and communities.

Under section 3011, the Secretary is instructed to invest in the health IT infrastructure necessary to allow for and promote the electronic exchange and use of

health information for each individual in the United States. As a result, it is imperative that the Beacon Community Program demonstrate the potential of health IT for all individuals, including those living in communities with a lower propensity to adopt health IT. To ensure the relevance of this program to individuals across the spectrum of diverse local health care environments in this country, the Beacon Community Program will strive to demonstrate the feasibility of strengthening the health IT infrastructure and achieving successful health IT-enabled improvements in health outcomes and system efficiencies in a variety of settings and populations, including rural and underserved communities and other vulnerable populations.

The substantial and Federal commitment to advance healthcare through health IT has created opportunities for coordination with existing and new Federal programs to extend the impact of the Beacon Communities. One such opportunity for coordination is with the Department of Defense and the Veterans Health Administration in their development of the Virtual Lifetime Electronic Record (VLER) initiative, which will create a system that will ultimately contain longitudinal administrative and medical information for all active duty military and retired military personnel. VLER rests on an internet-based, open architecture HIE that uses standards and other components of the Nationwide Health Information Network (NHIN). In addition, the Health Resources and Services Administration (HRSA) is funding Federally Qualified Health Centers (FQHCs) and Health Center Controlled Networks (HCCNs) to adopt certified EHRs and exchange health information. These health IT-enabled FQHCs and HCCNs are an important part of a community-wide effort to achieve widespread adoption of health IT. Furthermore, programs of the Departments of Agriculture and Commerce extend broadband infrastructure to places where it was not previously available and create opportunities for collaboration at a community level to use health IT and information exchange to achieve health care gains. By leveraging existing Federal resources and working in tandem with other key programs across the Federal government, the Beacon Communities are expected to maximize their efforts, extend their capabilities, and achieve farther reaching goals.

C. Project Structure

1. Approach

Substantial Federal involvement in the Beacon Community Program will be required, including ONC's close collaboration with recipients to ensure diversity of project aims, ongoing technical assistance and troubleshooting, and coordination with the Regional Health IT Extension Center Program and the State Health Information Exchange Program. Funds will therefore be obligated and disbursed after a competitive application process resulting in approximately 15 cooperative agreements with individual communities, including approximately 3 Virtual Lifetime Electronic Record Beacon Communities and at least 5 communities which address the needs of rural communities and/or minority and other underserved populations. Though Beacon Communities will likely represent a consortium of stakeholders, the Beacon Community proposal will be advanced by one "lead applicant" organization which will serve as the point of contact for the application process and become the recipient of the award. When necessary, the

lead applicant will be permitted to make subawards (subgrants) for approved activities to stakeholder organizations and/or other appropriate organizations according to all applicable federal regulations and guidelines. Communities should encompass existing OMB health care markets that display geographic, political and/or health care coherence. Such markets may consist of a hospital referral region (see http://www.dartmouthatlas.org), a political jurisdiction, or other well-defined medical market.

ONC will coordinate with the program management lead for each Beacon Community, and will require annual reports on progress and expenditures as part of the terms and conditions of the cooperative agreements. Beacon Communities will work with ONC through the cooperative agreement process to establish process metrics for inclusion in these annual reports. These annual reports will be in addition to those required by ARRA (specifications, requirements and tutorials for ARRA quarterly recipient reports are detailed in the federalreporting.gov downloads website, https://www.federalreporting.gov/federalreporting/downloads.do).

Eligible applicants must meet the review and selection criteria (Section V Application Review Information). Successful applicants must either 1) be able to demonstrate existing, advanced infrastructure for health IT and exchange; or 2) be able to demonstrate previous success and/or advanced core-competencies in either a) community-level practice redesign and care coordination or b) community-level evaluation, performance monitoring and feedback, with the intent to leverage existing expertise by advancing their health IT and exchange infrastructure. Generally, communities will be expected to have rates of EHR adoption that are significantly higher than published national estimates to qualify as Beacon Communities (see Section IV.B.2. Application Responsiveness Criteria). They will be required to detail their plans to advance their current capabilities within their established area of excellence **and** their plans to build their capabilities in the remaining two areas through health IT. Successful applicants will be held accountable for high levels of EHR adoption[1] and achievement of meaningful use among a majority of providers (see Section V.A Application Review Criteria), and information exchange across providers and organizations for quality improvement and care coordination purposes.

Applicants will be entities that meet the selection criteria below and can achieve high levels of EHR adoption and information exchange across organizations for quality improvement and care coordination. Communities will be selected based on the feasibility of their plan (as determined by objective review) to use their health IT infrastructure to achieve the goals of more cost-effective and higher-quality patient care and improved population health by the end of FY 2012; but they will be given flexibility in selecting process and outcome objectives and setting specific, high-impact, measurable, and ambitious yet achievable targets consistent with the scope of their proposed project. Cost savings and health improvements will be assessed both by the

[1] EHR adoption is defined as the basic use of electronic systems to substitute for paper charts -- specifically, clinical practice systems which permit patient tracking over time, clinical notes entry, and electronic access to test results; and which produce and transmit prescriptions electronically (Health Information Technology in the United States: Where We Stand, ONC and RWJF, 2008.).

Community itself, according to each Beacon Community's particular program goals and design, and externally, by ONC evaluation using a uniform set of criteria across communities (see Section I.D Evaluation). Each Beacon Community will be required to implement monitoring and reporting systems to aid in internal data collection concerning metrics for successful achievement of program-selected objectives, including expansion of health IT infrastructure and exchange, and the health outcome(s) and cost savings metrics proposed by the Beacon Community and agreed upon by ONC. These systems will serve to provide timely feedback to Beacon Communities on their progress and inform continuous feedback and improvement.

Successful applicants will be expected to use a strong, established community leadership team to organize and manage their efforts and leverage national, state, and local assets including municipal and state resources, large local purchasers, multi-payer collaboratives, and private industry. Applicants must also demonstrate how the funds from this program will be coordinated with the work of other entities that are promoting a health IT and HIE infrastructure, including, where relevant, Regional HIT Extension Centers and Health Information Organizations as well as the resources of other Federally funded HIT activities. These other activities may include:

- Department of Defense and the Department of Veterans Affairs Virtual Lifetime Electronic Record (VLER);
- Health Resources and Services Administration (HRSA)'s Federally Qualified Health Centers (FQHC) and Health Center Controlled Networks (HCCN);
- Indian Health Service;
- Centers for Medicare and Medicaid Services (CMS) demonstration projects;
- Medicaid transformation grants;
- Federally funded Broadband initiatives; and
- Other Federal funds assisting with HIT infrastructure.

While Federal funds will be used to accelerate the further establishment of existing HIT infrastructure for data analysis and feedback mechanisms and care coordination structures, there is an expectation that the local stakeholders will begin to use this information infrastructure to establish innovative third party payment models that can sustain these efforts. All participating providers will be expected to demonstrate meaningful use of EHRs as part of evaluations.

2. Use of Funds

Upon execution of its Cooperative Agreement with ONC, the successful Beacon Community will receive its award to be spent according to the following requirements. The communities must use the funding provided under this program to support health information technology and information exchange infrastructure, improvement and expansion of the use of health information technology by public health departments,

adoption of certified[2] electronic health records (of those applicants who will propose purchase of certified EHR technology, preference will be given to Communities that propose to purchase certified EHR technology only for providers ineligible for Medicare and Medicaid meaningful use incentive payments (as reflected in Section V.A. Application Review Criteria)), training on and dissemination of information on best practices to integrate health information technology into providers' delivery of care, infrastructure and tools for the promotion of telemedicine, communitywide quality reporting repositories and registries, engagement of patients and families in managing their health through better use of information and information technology, and the protection of health information by all holders of individually identifiable health information. These investments are expected to work together to promote the specific health care and population health goals of each community. It is expected that applicants' strategic plans and budgetary needs will vary based on their existing areas of excellence and specific health systems improvement objectives. Applicants will be required to submit detailed budget estimates that specify the allocation of funding required to achieve these outcomes in each of the following categories:

1) Health Information Technology and Exchange Infrastructure

Funds in this category should be used to advance the meaningful use[3] of health IT (as defined in the NPRM scheduled to be published in December 2009) across the community and to build the foundation for health IT-enabled health systems improvements. The cooperative agreement recipients shall ensure that where funds are expended under this section for the acquisition of health IT, such funds shall be used to acquire certified health IT. Communities will be expected to select vendors and acquire health IT which utilizes data standards and interoperability specifications promulgated by the Department, and to the extent practicable, uses the infrastructure enabled by the NHIN. Funds for health IT may not be duplicative of Federal funds allocated under other programs. In addition, for those Communities that propose to purchase certified EHR technology, preference will be given to those that limit support for the EHR technology to providers ineligible for Medicare and Medicaid meaningful use incentive payments (as reflected in Section V.A. Application Review Criteria). Allowable expenditures include:

a. Establishing and extending network infrastructure and Broadband access;
b. Partnering with an existing Regional Health Information Technology Extension Center to promote the adoption and meaningful use of EHRs (including among providers not eligible for health IT incentive payments);
    i. Supplementing existing (or establishing new) technical assistance contracts for regional extension centers to extend services to non-priority providers of the Regional Extension Center program (e.g.,

[2] A certified electronic health record is technology that has been tested and certified in accordance with the certification program (to be established by the National Coordinator via rulemaking) as having met all applicable certification criteria adopted by the Secretary.

[3] CMS is expected to release proposed ruling on Meaningful Use in December 2009.

specialists and primary care providers who do not currently qualify for federally-funded regional center assistance, providers in multi-site practices or practices with greater than ten primary care providers);

c. Integrating with State and local HIE efforts (including the VLER initiative) to enable safe, secure movement of information between organizations;
    i. Contracting for system interface development;
    ii. Purchasing servers, other hardware and software, and instituting systems necessary for the secure and appropriate exchange of information, such as those for locating records, authenticating providers and routing messages across providers and intermediaries;
d. Promotion of telemedicine and tools for flexible, off-site communication (e-visits, home monitoring devices, remote consults);
    i. Establishing technical infrastructure required for telemedicine (e.g., hardware and software, network connectivity, access to broadband);
    ii. Tools for the provision of remote care (e.g., monitoring equipment);
    iii. Tools to facilitate care communication and delivery that increases convenience for clinicians and patients/families;
e. Enabling bilateral communication with public health agencies;
    i. Contracting for the development of data collection systems, standards-based reporting functionalities and interfaces with local, state, and Federal public health agencies;
    ii. Building or advancing public health surveillance systems and activities related to population and quality improvement goals;
f. Enabling adoption of certified EHRs among targeted providers not eligible for Medicaid and Medicare meaningful use incentives;
    i. Purchasing certified EHR technology for providers who are not eligible for Medicaid and Medicare meaningful use incentives;
    ii. Extending the existing services of an ONC funded regional extension center to provide technical assistance to providers not eligible for Medicaid and Medicare meaningful use incentives through the mechanisms outlined in "1) Health Information Technology and Exchange Infrastructure, b. Partnering with an existing Regional Health Information Technology Extension Center…" above;
g. Enabling the health IT infrastructure, data mapping, and repositories needed for data aggregation and quality measurement, including applicable hardware, software, network and consulting costs;
    i. Purchasing hardware and software including databases and applications to enable the translation of various medical terminologies and codes to a common, computable format;
    ii. Purchasing software applications or services to enable the collection and analysis of data from different sources to derive numerators and denominators of quality measures; and
    iii. Purchasing software applications and services to enable web-based quality benchmarking, reporting and feedback of quality measures to providers.

2) **Integration of Health Information Technology Into Care Delivery**

Funds in this category should be used to promote utilization by providers of advanced functionalities of health IT systems and information exchange to enable progress on the specific and measurable health outcome improvement goal(s) proposed by the applicant and agreed upon by ONC. Allowable expenditures include:

a. Instituting clinically relevant decision supports for providers and patients (alerts, reminders, order sets) to inform clinical and shared decision making at the point of care;
b. Improving medication management (enabling medication reconciliation, monitoring and improving medication-taking);
c. Instituting use of registry functions (e.g., maintaining an electronic list of patients with the same chronic disease and utilizing that list to facilitate patient recall, reminders, scheduling of planned visits, and adherence to evidence-based guidelines);
d. Improving care coordination;
    i. Establishing the training, software, interfaces, and connectivity necessary to enable patient summary health information exchange across care settings and unaffiliated providers;
    ii. Creating processes and tools that facilitate continuous relationships between patients and their clinicians for better coordinated care;
    iii. Redesigning clinical workflow to ensure that technology supports ongoing exchange of information among clinicians and between clinicians and their patients/families to enhance the ability of all parties to have just-in-time information for risk reduction, health promotion, informed decision making, and ongoing care management;
e. Engaging patients and families;
    i. Developing a strategy for learning from patients and families about their health needs that can be better supported by technology (e.g, through consumer surveys, focus groups, structured interviews, ethnographic observation in clinical, home and work settings, and other methods);
    ii. Enabling the creation and facilitating the integration of after-visit summaries, patient portals, personal health records, self-management tools, patient decision aids, and/or patient kiosks through hardware and software purchases and contracts;
    iii. Purchasing certified software and/or applications to enable secure messaging between patients and providers;
    iv. Ensuring that providers integrate the above tools, systems and applications into their clinical workflow so that care management inside and outside the clinical delivery setting are well-coordinated;
    v. Providing patient education and instructional materials around health IT-enabled patient-empowerment and self-management;
    vi. Integrating information from outside the delivery system (e.g., pertinent health information collected at home by patients and their families) into provider information systems;

vii. Building processes, tools and infrastructure that facilitates translation of clinical and administrative data into meaningful, useful information for patients and families; and

f. Promoting technologies and best practices that enhance the protection of health information by all holders of individually identifiable health information.

3) Evaluation, Performance Monitoring and Feedback

Funds in this category should be used to monitor and evaluate the progress towards the health care and population health goals of the Beacon Communities through strengthened Health IT infrastructure and exchange. Allowable expenditures include:

a. Establishing systems for measurement and feedback of health systems quality, safety, and costs relevant to project goals (including applicable software, hardware, network connectivity and consultancy and costs);
b. Enabling transparency across care settings related to performance and quality;
c. Modeling and projecting cost savings via reduction of preventable hospitalizations, prevention of hospital readmissions, reduction of emergency room visits, improvement in medication therapy management, efficiency improvements, reduction in redundant and inappropriate diagnostic services, and prevention of hospital-acquired conditions (including all applicable software, hardware and consultancy costs);
d. Identifying innovations that promote high quality and high-value care;
e. Identifying and disseminating best practices for the adoption and meaningful use of health IT; and
f. Assessing the impact on patients and families in terms of:
   i. Consumers' experience with care;
   ii. Consumers' self-reported access to meaningful, useful information; and
   iii. Consumers' self-reported ability to manage their health and make informed decisions.

4) Operational Costs and Overhead

In addition, funds may also be used to support operational costs and overhead, which will enable or support Beacon Community activities in the three categories above. Any of the funds expended in this category must be directly allocable to the Beacon Community project and associated activities. If the applicant organization/consortium has a current indirect cost rate negotiated with HHS or any Federal agency, that rate should be included in the application, and the applicant must further ensure that, if successful, no charges in the indirect cost pool will be charged directly.

Allowable expenditures include:

a. Staffing and Personnel Costs;
b. Fringe Benefits;
c. Travel;
d. Equipment; and
e. Supplies.

Funding in each of these categories may complement, but must not be duplicative of, other Federal programs, including State HIE Program and regional HIT extension centers. For example, the State HIE Program will ensure the basic infrastructure for information exchange, while the Beacon Community Program might focus on further developing and strengthening that infrastructure to improve care coordination, reduce duplicative testing and avoid medication errors. The extension center program will provide technical assistance for EHR adoption and meaningful use of primary care providers by 2011, while the Beacon Community Program might help accelerate EHR adoption by providing additional funds for certified EHR technology for those providers ineligible for other incentive programs and extending services to providers not covered under the Regional Extension Center cooperative agreements (e.g., "non-priority" providers, specialists and large practices). More importantly, the Beacon Community Program will support the development and implementation of advanced processes that build on the capacity of EHRs to target patients at greatest need for improved disease management and information exchange to facilitate linkages between providers across the spectrum of care.

Finally, the Beacon Communities will work with the Health Information Technology Research Center to provide training and disseminate information on best practices for the use and integration of health IT, including EHRs, in order to provide support and assistance to other communities that are working to develop and strengthen their own health IT infrastructure. This includes participation in regional and national network meetings, sharing experiences with barriers and solutions, and sharing of locally developed materials or tools.

D. Evaluation

The main objective of the evaluation will be to demonstrate that a robust health IT infrastructure, and training on and dissemination of information on best practices to integrate this technology into a provider's delivery of care, can enable communities to achieve the goals of higher quality, more cost-efficient, patient-focused health care, and improved population health (including public health, quality improvement, and emergency preparedness). Each successful applicant will be required to monitor their progress on internally collected care process and outcome metrics proposed by the Beacon Community and refined through the cooperative agreement process, and to participate in an external evaluation, conducted by an independent contractor through a separate competitive award process.

Goal 1. Higher Quality, More Cost-Efficient, Patient-Focused Health Care.

Beacon Communities must develop community-wide action plans to strengthen the health IT and information exchange infrastructure to improve patient-centric care, in which information follows the patient across provider or network boundaries, regardless of where the patient goes. Communities will be given flexibility in selecting process and outcome objectives and setting specific, measurable, and ambitious yet achievable targets

consistent with the scope of their proposed project that demonstrate how they use their health IT infrastructure to achieve the goals of more cost-effective and higher quality patient care and improved population health by the end of FY 2012. Communities must design metrics in each of two categories, including:

A) Cost efficiency. Metrics may include preventable emergency room visits and hospitalizations (including readmissions), hospital-acquired complications, redundant and inappropriate diagnostic services, or generic prescribing.
B) Quality. (e.g., blood pressure control, lipid control, diabetes control, adverse drug events).

Applicants must propose to achieve higher quality, more cost-efficient healthcare by advancing the meaningful use of health IT and patient-centric exchange within their community. There must be observable improvements in community-selected metrics of cost-efficiency and quality that can be collected, analyzed, and used to provide feedback to community participants during the project's performance period. These metrics will be used by the external evaluator at the end of the 36-month performance period.

Goal 2. Population Health. Beacon Community proposals must also develop a community-wide strategy to achieve health IT-enabled improvements in population health. To this end, communities must select specific and measurable metrics for measuring progress in at least one of the following categories:

A) Tobacco control;
B) Preventive health services (e.g., immunizations, recommended cancer screenings, prenatal care);
C) Health disparities (e.g., for minority and/or underserved populations, or through the use of telemedicine in rural communities)
D) Public health surveillance (e.g., timeliness and completeness of communicable disease reporting, real-time monitoring for influenza morbidity)

As with cost outcomes, the health metrics chosen will vary depending on the aims of the cooperative agreement recipient, but must be routinely monitored with feedback provided to community participants, and directly translatable into expected contributions to life expectancy, quality of life, or community health.

Demonstrating Cost Savings Across All Communities

Community efforts should be designed to have an impact on overall costs and quality and on the Medicare program specifically. Cost savings will ultimately be quantified in terms of trends in risk-adjusted per-capita costs within the area served by the awardee, compared to matched control communities. Control communities will be selected that are similar to the Beacon Communities in terms of community size and composition, health status, health care services (e.g., physicians and hospital beds per capita) and other

factors as defined by the methodologies in the Dartmouth Atlas of Health Care. Sub-analyses will examine specific utilization patterns and medical practices actively participating in their community's Beacon Program. Sites will be expected to provide sufficient information on the participating practices (e.g. TINs) to perform the sub-analyses. In addition to the general evaluation of costs, the ONC external evaluation will also include, at a minimum, the impact of the program on the metrics below.

- Hospitalizations for ambulatory care sensitive conditions
- Hospital re-admissions for selected conditions
- Percentage of elderly prescribed inappropriate (per Beers criteria) medications

Specialized analyses may be conducted by ONC's external evaluator using sources such as Medicare data, Medicaid data, and/or State Healthcare Cost and Utilization Project (HCUP) data, depending on the primary programmatic emphasis of the Beacon projects. This portion of the evaluation is expected to be completed by December 2013 and will be coordinated with CMS. ONC will also collaborate with the Assistant Secretary for Planning and Evaluation (ASPE) on all evaluation activities. Other participating agencies will also serve in an advisory capacity to the external evaluation.

Evaluation of Care Process and Outcome Metrics

Beacon Communities will develop action plans to improve cost and health outcomes in ways that meet the needs of their communities. Given the burden of chronic diseases such as hypertension, coronary artery and other cardiovascular diseases, diabetes, and asthma on patients and health systems, care process and outcome metrics that tie back to chronic disease management shall be prioritized. These metrics might, for example, focus on using health IT for improving adherence to medications, increasing access to culturally-competent primary care, or streamlining interactions between providers and health plans to improve chronic disease management. Whatever approaches to improving care processes and health outcomes a Beacon Community proposes, they must be expected to yield observable improvements by the end of FY 2012 that can be collected, analyzed, and fed back to community participants during the project's performance period, and used by the external evaluator at the end of the 36-month performance period. Examples of the types of care process metrics that could be monitored and improved by leveraging standards- based interoperable and meaningfully used EHRs, health information exchange organizations, and multi-payer collaboratives are listed below.

1) Reduction of preventable hospitalizations;
    a. Ambulatory care-sensitive hospitalizations
    b. Potentially avoidable complications
    c. Short-stay hospitalizations due to missing information
    d. Hospital readmissions
2) Reduction of emergency department visits;
    a. Ambulatory care-sensitive emergency department visits
3) Improvement in medication therapy management

    a. Percent of prescriptions submitted that are generic (electronically and overall)
    b. Rate of adverse drug interactions
    c. Rate of inappropriate medications for the elderly (e.g., according to Beers criteria for potentially medication inappropriate use in older adults)
4) Improvement in administrative efficiency;
    a. Percent of claims submitted electronically
    b. Percent of claims requiring additional processing/coordination of benefits
5) Reduction in redundant and inappropriate diagnostic services;
    a. Percent of diagnostic tests repeated within clinically inappropriate window
    b. Percent of clinically inappropriate diagnostic tests ordered
6) Prevention of hospital-acquired conditions
    a. Hospital-associated infections
    b. Hospital-associated venous-thrombosis events

ONC and its evaluation contractor will work with Beacon Communities on methods for measuring these gains and translating them into dollar savings.

Demonstrating Health Improvements. As with cost outcomes, both clinical/individual and population-based health metrics chosen will vary depending on the aims of the awarded Beacon Community, but must be routinely monitored and fed back to community participants, and directly translatable into expected contributions to relevant health care outcomes (examples of these different types of metrics are provided below). Awardees are expected to choose from amongst these outcomes or propose specific metrics of their own that relate to their programmatic focus. Awardees must choose at least one metric that can be tied directly to health improvements, preferably for patients with chronic disease (e.g., improvements in blood pressure control can be tied to fewer acute events and reduced morbidity and mortality). Examples of potential metrics are listed below by category of metric:

Goal 1. Higher Quality, More Cost-Efficient, Patient-Focused Health Care.

1) Patient Clinical Outcomes
    a. Blood pressure control
    b. Lipid control
    c. HgA1c in diabetics
2) Patient Safety
    a. Adverse drug events
    b. Iatrogenic events
3) Patient Experience
    a. Patient experience with care
    b. Percent of patients able to access timely care (e.g., in FQHCs or through telehealth)
    c. Percent of encounters requiring translation provided with translators, bilingual staff (cultural competency)

d. Percent of patients using health portals/personal health records (PHRs) in their primary language
e. Patients' self-reported access to meaningful, useful information
f. Patients' self-reported ability to manage their health and make informed decisions

Goal 2. Population Health.

1) Smoking Rates/Cessation
2) Health Disparities
   a. Disparity in receipt of health services by racial/ethnic group, urban/rural, vulnerable populations
   b. Disparity in health outcomes by racial/ethnic group, urban/rural, vulnerable populations
3) Public Health
   a. Percent of Hepatitis A reports received in time to initiate immune globulin prophylaxis
   b. Percent of Meningococcal (*Neisseria meningitides*) reports received in time to initiate antibiotic prophylaxis
   c. Percent of high-priority population that has received influenza vaccination

As with the cost outcomes, cooperative agreement recipients will be assisted with data collection methodologies and analysis by ONC and its evaluation contractor.

E. Statutory Authority

The statutory authority for awards under this Funding Opportunity Announcement is contained in Section 3011 of the Public Health Service Act (PHSA) as amended by the American Recovery and Reinvestment Act of 2009 (P. L 111-5) (ARRA). Awards under Section 3011 are subject to Section 3017 (a) & (b) as detailed in Appendix A.

II. Award Information

A. Summary of Funding

Type of Award	Cooperative Agreement
Total Amount of Funding Available in FY2010	$220,000,000
Average Award Amount	$15,000,000
Award Floor	$10,000,000
Award Ceiling	$20,000,000
Approximate Number of Awards	15
Project Period Length	36 months
Successful Applicants Selected	2/2010
Cooperative Agreements Issued	3/2010
Anticipated Start Date of the Agreement	4/2010

B. Type of Award

Awards will be in the form of a 36-month cooperative agreement with each Beacon Community. A cooperative agreement, as opposed to a grant, is an award instrument of financial assistance where substantial involvement is anticipated between ONC and the recipient during the performance of the project.

Under this type of award, in addition to the usual monitoring and technical assistance, ONC responsibilities include the following:

- working with each Beacon Community in a collaborative manner to refine the Community's proposed quality, cost-efficiency, and population health improvement goals and metrics in accordance with the criteria set forth in the Noticed of Proposed Rule Making for meaningful use[4];
- facilitating the selection of terms for annual milestones;
- participating in developing and implementing activities that will facilitate the Community's achievement of these goals; and
- review of project information prior to dissemination;
- assistance and referral in the establishment and facilitation of effective collaborative relationships with Federal and State agencies, resource centers, and other entities that may be relevant to the project's mission
- provision of information resources;
- participation in the dissemination of project activities and products; and
- facilitating an external evaluation of the project.

The applicant/recipient, in collaboration with ONC, must:

- propose health IT enabled health care quality, cost-efficiency, and population health improvement goals and metrics in accordance with the criteria set forth in the Noticed of Proposed Rule Making for Meaningful Use and refine these metrics with ONC guidance and support;
- develop community-wide action plans to strengthen the health information technology and information exchange infrastructure to improve specific aspects of the delivery of health care to individuals within the 36-month period of support;

[4] Notice of Proposed Rule Making (NPRM) for Meaningful Use is expected to become public in December 2009. It is anticipated that Beacon Community applicants will refer to the NPRM when it becomes available and work with ONC through the Cooperative Agreement process to refine the metrics to align with the proposed criteria for Meaningful Use. Metrics selected by awardees that are not in the final rule can remain in the evaluation plan.

- coordinate and execute activities in three categories and the core area outlined above to achieve project goals,
- monitor project progress through internal collected care process and outcome metrics, and
- participate in an external evaluation.

The award of funding will be contingent on recipients' full participation in these and other collaborative activities as outlined in the Cooperative Agreements.

C. Funding Description

Timing of Milestones:

A competitive award process will be used beginning with the release of this Funding Opportunity Announcement in December 2009. Following a 60-day application period and objective review by a panel of Federal and non-Federal experts, cooperative agreements are expected to be awarded in March of 2010. Applicants must be able to demonstrate that they can achieve their internal processes and outcome goals by the end of FY 2012. Evaluation of cost data across all sites will occur following the availability of Medicare claims data files in 2013 (see Section I.D Evaluation).

Fiscal Year of Obligation:

Approximately $220 million will be obligated in FY 2010 and expended through the end of FY 2012 for Beacon Communities, at a range of $10-20 million per community.

Accountability: The following steps will be taken by ONC and the awardees to increase program accountability and minimize financial risk:

- The strength of each community's project leadership team and project management structure and the demonstrated success of the applicant in previous health IT-enabled initiatives will be key factors in the selection criteria.
- ONC will ensure that each cooperative agreement will be assigned to an experienced, qualified, Federal grant manager and a program manager on performance measures. Managers will be held to a high standard of accountability in achieving program goals under the Recovery Act.
- ONC will require selected applicants to provide a detailed project plan and detailed timeline with measurable milestones relating to establishment of organizational capacity (including adequate staffing), establishment of data collection and reporting systems, progress towards health IT and care coordination infrastructure, and appropriate fiscal management.
- ONC will work with Beacon Community awardees through the cooperative agreement process to set performance-based terms and mutually agreeable process measures.

- Each successful applicant will submit quarterly ARRA reports and yearly program reports to the grant manager.
- The ONC grant manager and ONC program manager assigned to each cooperative agreement will meet monthly with the project leadership to evaluate performance in relation to the project plan to ensure that work is on time, within budget and meeting requirements such as following national technical standards, privacy and security guidelines, etc.
- Each cooperative agreement will include reporting requirements in order to enhance transparency and comply with Section 1512 of the Recovery Act.

III. Eligibility Information

A. Eligible Applicants

Crucial to the success of each Beacon Community is the governance structure and experience required to accelerate the development of health IT infrastructure and exchange capabilities in accordance with program goals. In order to ensure that funded Beacon Communities have the basic capacity and organizational structure necessary to succeed, ONC requires the lead applicant for a Beacon Community to be a US-based non-profit organization or a government entity falling into one of the following five categories:

1) State, local, tribal, or territorial government entity with a public health focus
2) Integrated delivery network or health system with broad community partnerships
3) Independent physician association or consortium of medical groups
4) Public/private partnership aimed at health system improvement and/or community health improvement
5) ONC-funded regional extension center with the capacity to expand its services

The Beacon Community may represent a consortium of stakeholder organizations and healthcare providers. For purposes of this cooperative agreement, stakeholders include, but are not limited to, primary care providers (PCPs), practicing clinicians, hospitals, public and private payers, consumers, local and state public health departments, safety net providers, employers, academic institutions, charitable foundations, industry, laboratories, pharmacies, employers, quality improvement organizations, hospital associations, government entities, and medical societies. Proof of non-profit status is required for all non-profit applicants.

B. Cost-Sharing

Cooperative Agreement recipients will not be required to match Federal funds.

IV. Application and Submission Information

A. Address to Request Application Package

Application materials can be obtained from http://www.grants.gov.

Letters of intent to apply and all attachments should be emailed to BeaconCommunityGrants@hhs.gov on or before 11:59 PM on January 8, 2010. Required content for letters of intent can be found in Appendix H. Applicants will receive an automatic email notification from the email address that demonstrates the email was received. This notification does ***not*** provide assurance that your application was complete, only that the email was received. After ONC reviews your email submission, a return receipt will be emailed to the originating e-mail address indicating the files that were received and able to be successfully opened and read. Due to the volume of letters of intent received, this receipt may not be available for several days; applicants are strongly encouraged to submit letters of intent as far in advance as possible if they wish to receive confirmation of receipt prior to the deadline.

Applications for all announcements must be submitted electronically through http://www.grants.gov. The grants.gov registration process can take several days. If your organization is not currently registered with http://www.grants.gov, please begin this process immediately. For assistance with http://www.grants.gov, please contact them at support@grants.gov or 1-800-518-4726 24 hours a day, 7 days a week (excluding Federal holidays). At http://www.grants.gov, you will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the grants.gov website.

- Applicants shall access the electronic application for this program on http://www.grants.gov. Applicants must search the downloadable application page by the Funding Opportunity Number HHS-2010-ONC-BC-004 or by the CFDA Number 93.727.
- At the http://www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. ONC strongly recommends that you do not wait until the application due date to begin the submission process through http://www.grants.gov.
- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number and register in the Central Contractor Registry (CCR). You should allow a minimum of five days to complete the CCR registration. You can register with the CCR online (http://www.ccr.gov). If you have already registered with CCR but have not renewed your registration in the last 12 months, you will need to renew your registration at http://www.ccr.gov.
- Applicants must submit all documents listed in Appendix J Required Documents for Beacon Community Applications electronically, including all information included on the SF-424, the SF-424A – Budget Information for Non-Construction Programs, the SF-424B – Assurances for Non-Construction Programs, the Project/Performance Site Location form, and all necessary

attachments (i.e., the project abstract, narrative, budget justification, Appendix E, etc.). The maximum allowable file size of the full application, including all attachments, is 250 MB.

- Applicant must submit all Application documents electronically on or before 5:00 p.m. Eastern Standard Time **February 1, 2010**.
- Prior to application submission, Microsoft Vista and Office 2007 users should review the Grants.gov compatibility information and submission instructions provided at http://www.grants.gov (click on "Vista and Microsoft Office 2007 Compatibility Information").
- Your application must comply with any page limitation requirements described in this Funding Opportunity Announcement.
- After you electronically submit your application, you will receive an automatic acknowledgement from http://www.grants.gov that contains a grants.gov tracking number. ONC will retrieve your application from grants.gov.
- After ONC retrieves your application from grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by Grants.gov.

APPLICATIONS CANNOT BE ACCEPTED THROUGH ANY EMAIL ADDRESS. APPLICATIONS CANNOT BE ACCEPTED THROUGH ANY WEBSITE OTHER THAN http://www.grants.gov . APPLICATIONS CANNOT BE RECEIVED VIA PAPER MAIL, COURIER, OR DELIVERY SERVICE.

APPLICANTS ARE STRONGLY ENCOURAGED TO COMPLETE AND SUBMIT APPLICATIONS AS FAR IN ADVANCE OF THE SUBMISSION DEADLINE AS POSSIBLE. THE APPLICATION INCLUDING ALL REQUIRED ATTACHMENTS AND FILES FOR POTENTIAL CONSIDERATION IN THE REVIEW PROCESS MUST BE RECEIVED BY 5:00 PM EASTERN TIME ON THE DATE SPECIFIED IN SECTION IV.D, BELOW.

Key Contact for Applications:

Inquiries should be addressed to:

U.S. Department of Health and Human Services

Office of the National Coordinator for Health Information Technology

Email: BeaconCommunityGrants@hhs.gov

B. Application Screening and Responsiveness Criteria

1. Application Screening Criteria

This section outlines administrative criteria that are required of all applicants. Applications will not move forward to objective review unless these screening criteria are met.

- The applicant submits a complete and timely application, including the timely submission of a letter of intent to apply.
- Application demonstrates eligibility requirements addressed in Section III, Eligibility Information.
- Project Narrative does not exceed 50 double-spaced pages. The 50-page limit excludes resumes, letters of support, Sustainability Plan, Program Abstract, and other attachments.
- The total page limit for the application, including all attachments, resumes, letters of support, Sustainability Plan, Program Abstract, budget forms and appendices, does not exceed 120 pages.

2. Application Responsiveness Criteria

This section outlines content criteria that are required of all applicants.

- Application includes responses to all required questions in Section IV. C, with numeric responses where specified. This information should be re-submitted with the application, regardless of whether the information is embedded in the applicant's Letter of Intent; and
- One of the principal goals of the applicant organization, as stated in the applicant's Project Narrative, is to promote the use of health IT to achieve specific and measurable cost-efficiency and quality and/or population health improvement goals through the authorized and secure electronic exchange and use of health information; and
- The applicant certifies that it has adopted nondiscrimination and conflict of interest policies that demonstrate a commitment to transparent, fair, nondiscriminatory, and unbiased service to its geographic service area. The applicant does so by completing Appendix E and including it in their application package; and
- The level of EHR adoption within the geographical area represented by the Beacon Community meets the following minimum criteria[5]:

[5] ONC may verify estimated EHR adoption rates through nationally available data sources. These minimum criteria will ensure that the applicants are prepared to meet the program goals including achieving 60% of primary care providers using certified EHRs and qualifying for meaningful use incentives. Communities with a more advanced health information technology infrastructure will support the development of the nationwide electronic exchange and use of health information in a secure, private, and accurate manner.

- If the geographical area is urban[6], at least 30% of all healthcare providers must have adopted EHRs according to the definition set forth in this FOA;

---OR----

- If the geographical area is rural[7], at least 25% of all healthcare providers must have adopted EHRs according to the definition set forth in this FOA;

---AND---

- The applicant must include at least one Level 3 or 4 Stakeholder (see Section IV.C.8 Collaborations and Letters of Commitment from Key Participating Organizations and Agencies).

C. Content and Form of Application Submission

1. Letter of Intent to Apply

Applicants must submit a letter of intent to apply for this funding opportunity. Those organizations which do not submit a letter of intent to apply will not be considered eligible, and their applications will not be reviewed. The purpose of this letter is to inform ONC about the potential geographic diversity, health improvement goals, and readiness of communities that intend to apply. These letters will give ONC a preliminary indication if there are a group of communities that could collectively meet the geographic diversity objectives and other selection criteria described in this Funding Opportunity Announcement. This letter must be submitted electronically via e-mail by the organization that will act as the lead applicant on behalf of the proposed Beacon Community. The letter of intent must be no longer than 5 pages. The letter of intent must be received by 11:59 pm, EST, January 8, 2010. The required content for this letter is included in Appendix J.

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[6] To be considered "urban" the geographic area represented by the Beacon Community must consist primarily of counties designated as parts of Metropolitan Areas (MAs) by the Office of Management and Budget (OMB). The current list of MAs, issued in 2003, and updates are available on the Internet at http://www.census.gov/population/www/metroareas/metrodef.html

[7] All counties that are not designated as parts of Metropolitan Areas (MAs) by the Office of Management and Budget (OMB) are considered rural. It is noted that large parts of many "urban" counties may be rural in nature. Therefore, we are permitting the designation of "Rural" areas within MAs. Census tracts with Rural Urban Commuting Area Codes (RUCA) 4 through 10 will be considered rural for the purposes of the Beacon Community Program. More information on RUCAs is available at http://www.ers.usda.gov/briefing/Rurality/RuralUrbanCommutingAreas/. If a community contains a rural area as defined by the RUCA codes, the geographical area will be considered rural for the purposes of this funding opportunity.

2. DUNS Number

The Office of Management and Budget (OMB) requires applicants to provide a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number when applying for Federal grants or cooperative agreements on or after October 1, 2003. It is entered on the SF 424. It is a unique, nine-digit identification number, which provides unique identifiers of single business entities. The DUNS number is free and easy to obtain.

Organizations can receive a DUNS number at no cost by calling the dedicated toll-free DUNS Number request line at 1-866-705-5711 or by using this link to access a guide: https://www.whitehouse.gov/omb/grants/duns_num_guide.pdf.

3. Tips for Writing a Strong Application

Tips for writing a strong application can be found at HHS' GrantsNet site at http://www.hhs.gov/grantsnet/AppTips.htm.

4. Proof of the Applicant's Status as a Non-Profit Entity

If an applicant is a US-based non-profit entity it must provide documentation of its 501C status or IRS determination letter, IRS tax exemption certificate, or letter from state taxing body verifying tax-exempt status. If the proposal is on behalf of a consortium, there must be letters of commitment from all members of the consortium which include their tax status.

5. Project Abstract

Applicants shall include a one-page abstract (no more than 500 words) of the application. This abstract is often distributed to provide information to the public and Congress and represents a high-level summary of the project. As a result, applicants should prepare a clear, accurate, concise abstract that can be understood without reference to other parts of the application and that provides a description of the proposed project, including: the project's goal(s) (including description and justification of healthcare improvement goal), objectives, overall approach, anticipated outcomes, products, and duration.

The applicant shall place the following information at the top of the Project Abstract (this information is not included in the 500 word maximum):

- Project Title
- Service area included in the application, described by county and USPS zip codes: zip-three code(s) for one or more entire counties, zip-five codes for any partial-county areas included in the proposed service area
- Applicant Name

- Address
- Contact Name
- Contact Phone Numbers (Voice, Fax)
- E-Mail Address
- Web Site Address, if applicable

6. Project Narrative

The Project Narrative must be double-spaced, formatted to 8 ½" x 11" (letter-size) pages with 1" or larger margins on top, bottom, and both sides, and a font size of not less than 12 point. The maximum length allowed for the Project Narrative is 50 pages. A full application with a Project Narrative that exceeds 50 pages will not be accepted. The Sustainability Plan (see Section IV. C. 7.), Letters of Support and resumes of Key Personnel are not counted as part of the Project Narrative for purposes of the 50-page limit, but all of the other sections listed below are included in the limit.

The Project Narrative is the part of the application that will offer the most substantive information about the proposed project, and it will be used as the primary basis to determine whether or not the project meets the minimum requirements for awards under ARRA. The Project Narrative should provide a clear and concise description of your project.

(Note: a concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed via the Web at: http://www.hhs.gov/grantsnet/AppTips.htm)

a. Current State and Gap Analysis of EHR Adoption and Meaningful Use

Applicants are expected to complete a current analysis of the state of EHR adoption and meaningful use and determine gaps within their service areas. ONC may verify estimated EHR adoption rates through nationally available data sources. The applicant should propose a detailed geographic service area (by county and zip 5) and the distribution of providers (by practice/facility type and size) which will be involved in the project. The geographical area that composes the proposed Beacon Community should include, at minimum, a defined Hospital Referral Area (see http://www.dartmouthatlas.org), political jurisdiction, geographical border, or Metropolitan Service Area. The service area will be finalized as part of the cooperative process between HHS and applicants. Considerations for HHS will include the desire for geographic diversity, as well as the:

- Number of providers targeted for direct assistance, and the proportion this number represents of the total number of providers in the proposed service area.

- Uninsured, underinsured, medically underserved and minority individuals as a proportion of the service area's total population.
- Number of Federally Qualified Health Centers (FQHC) and public and non-profit Critical Access Hospitals (CAH) in the service area at which primary-care professionals with prescriptive privileges furnish outpatient primary-care services, and the proportion of these facilities participating.
- Partnership or collaboration with a community college or other institution of higher education offering a certificate or associates degree program(s) in health information technology or related field (please specify).
- Presence within or in close proximity to the service area of a VA hospital, DOD medical facility, IHS or other Tribal health facility.
- Presence of organization(s) to provide for and/or extent of existing infrastructure(s) providing the secure electronic exchange of health information within the geographic service area (please specify and briefly describe).
- Labs, pharmacies, diagnostic centers, and other entities targeted for collaboration.

b. Goals and Objectives

The applicant should demonstrate in this section the vision, short-term/long-term goals and objectives that it will use to guide its operations. Specifically, applicants must provide a detailed description of the specific and measurable health IT infrastructure and exchange, cost-efficiency, quality and population health improvement goal(s) of the proposed services, as well as background justification for its prioritization (note that every applicant must identify at least one cost-efficiency goal, at least one quality improvement goal, and at least one population health improvement goal in order to be considered for funding. These goals need not be mutually exclusive (e.g., a proposal to improve blood pressure control in minority and underserved populations can be tied to fewer acute events and reduced morbidity and mortality as well as reduction in health disparities)). This section should include the baseline (or best estimate) for the selected cost-efficiency and health outcome(s) goals in the community and the degree of improvement which the Beacon Community hopes to accomplish through the use of coordinated health IT systems. Applicants must also reinforce herein their commitment to reduce healthcare systems costs through the proposed interventions and document their specific and measurable financial goals and objectives.

c. Proposed Strategy

In addition to a minimum level of EHR adoption as defined in Section IV.B.2. Application Responsiveness Criteria, every applicant must be able to demonstrate previous success and/or advanced core-competencies in Health Information Technology and Exchange Infrastructure, Practice Redesign and

Care Coordination, or Evaluation, Performance Monitoring and Feedback. An advanced level of health IT and exchange infrastructure should be demonstrated in this section by providing realistic estimates of EHR adoption and exchange in the community, with full disclosure of the methods used to achieve the estimates. In order to demonstrate previous success and/or advanced core-competencies in either of the remaining categories, applicants should reference (and submit as attachments) published articles in peer-reviewed journals and/or media articles covering applicants' activities and successes.

In this section, applicants must then detail their plans to advance current capabilities within their established area of excellence and their plans to build their capabilities in other areas critical to promoting health and health systems improvement using Health IT, including the specific steps they plan to take in order to build and strengthen their health IT infrastructure to enable achievement of their specific cost-efficiency, quality, and population health improvement goals. There must be a specific discussion and distinct relationship between the proposed health IT and exchange activities, care coordination activities, and performance improvement activities as well as an explanation of how the specific and collective activities will achieve the chosen cost-efficiency, quality and population health improvement goals. In addition, applicants must detail their plans to provide assistance to other communities that are seeking to develop and strengthen their HIT infrastructures, including but not limited to their intent to identify and disseminate best practices through the HITRC.

The applicant must detail the services that it will provide, and which among its stakeholders will be providing each service, in order to accomplish the scope of work detailed in Section I.C Project Structure. Applicants should pay particular attention to the following (see Section V.A Application Review Criteria for more detail):

- Area of excellence and support for achievements
- Establishment of an advanced health IT infrastructure
    - Achieving EHR adoption and meaningful use among at least 60% of primary care providers
    - Enabling health information interoperability and exchange using data standards and NHIN specifications
- Achievement of specific and measurable health improvement goals detailed in the Project Narrative
- Achievement of cost savings goals detailed in Project Narrative

d. Populations with Specific Needs

The applicant will also state how the unique needs of providers serving American Indian and Alaska Native, non-English speaking and other historically

underserved populations as well as those that serve patients with maternal, child, long-term care, and behavioral health needs, will be met.

e. Project Management

This describes how the Beacon Community applicant plans to govern and manage the execution of its overall program. It will include the Beacon Community's governance structure, roles/responsibilities, operating procedures, composition of committees, workgroups, teams and associated leaders, and communications plans that will provide adequate planning, monitoring, and control to the overall project. The project management activities should provide details on how plans and decisions are developed and documented, issues/risks managed, and meetings facilitated. Mechanisms to ensure accountability across community participants and incremental progress in achieving milestones necessary for health and health systems improvement must be specified.

If the applicant proposes to serve one or more entire states and/or territories, the applicant organization must demonstrate how it will effectively and efficiently carry out its strategic plan across its geographical catchment area.

f. Core Performance Measures

Applicants must detail in this section their strategy for collecting the following information on core performance measures, which Beacon Communities will be required to report to assess their progress towards 1) implementing their Strategic and Organizational Plan and 2) meeting their goals and objectives. In addition to the quarterly reports required for recipients of ARRA funds, yearly reports will be required covering the following areas:

1) Strategy and Management:
   - Organizational Capacity: Proportion of key staff hired and in place, organizational structures operational, and how this meets, exceeds, or falls short of plans
   - Health IT Infrastructure: Progress towards the health IT infrastructure and meaningful use targets outlined in their project plan, and how this meets, exceeds, or falls short of plans
   - Integration of Health IT into Care Delivery: Implementation of care coordination and performance monitoring and feedback system(s), and how this meets, exceeds, or falls short of plans
   - Appropriate Fiscal Management: Expenditures consistent with organization's Strategic Plan and Budget, and how this meets, exceeds, or falls short of plans
2) Goals and Objectives:
   - Data collection and measurement: Awardees must demonstrate that they are collecting, analyzing and reporting the data needed to document progress towards their goals. Verified baseline data must be submitted no later than 4 months after award.

- Cost-efficiency metric(s): Report on each of the metrics proposed, and how this meets, exceeds, or falls short of plans.
- Quality and Population Health improvement metric(s): Report on each of the metrics proposed, and how this meets, exceeds, or falls short of plans.

g. Evaluation

Recipients will be required to maintain information relevant to achieving the milestones specified in Section I.D Evaluation. This section should detail the applicant's plan to implement monitoring and reporting systems to aid in internal data collection around metrics for successful achievement of program goals, including expansion of health IT infrastructure, the health outcome(s) of choice, and the cost savings metrics proposed by the Beacon Community and agreed upon by ONC. Recipients will also be required to participate in the external evaluation and report performance metrics, as described above.

h. Coordination and Continual Improvement

The applicant should detail in this section its plans to utilize the systems described (see Section I.C.2. Use of Funds) in order to provide timely feedback to Beacon Community participants on their progress and inform continual improvement. The applicant should also affirm its commitment to collaborate with other Beacon Communities and regional extension centers through participation in HITRC organized activities and communication of best practices.

i. Organizational Capability Statement

This section describes the current capability possessed by the Beacon Community Applicant to organize and operate effectively and efficiently. This includes:

- A cover letter signed by the designated authorized representative of the organization serving as the lead applicant on behalf of the proposed Beacon Community, which includes the organizational mission statement.
- 2009 annual budget and sources of income.
- Number and roles of FTE staff in different functional areas (outreach/ communications, health IT implementation, workflow and process redesign, interfaces and information exchange, hardware and network infrastructure, quality improvement, privacy and security, other).
- Identification of key staff who will provide substantive work for each area covered in Section I.C Project Structure, and provide 1-page resumes for these individuals (please submit these resumes as attachments to the application).
- Previous experience with EHR implementation (number of existing vendor contracts, practices, practice sites, and providers served).
- Previous experience with workflow redesign and clinical quality improvement (number of practices, practice sites, and professional providers served).

- Previous experience with outreach, education and particularly on-site direct technical assistance in EHR adoption, implementation and meaningful use, functional, standards-based interoperability and health information exchange, and technical assistance around Federal and State Privacy and Security requirements.
- Any other relevant experience that aligns with the program goals and objectives.

7. Sustainability Plan

Beacon Communities are expected to realize cost savings and health improvements from the widespread use of standards-based interoperable health IT. If Beacon Communities are successful in this respect, their efforts will be sustainable by their community beyond the 36 month cooperative agreement through a clear return on investment. The applicant should detail herein their plan for achieving sustainability, which will necessarily refer to the applicant's cost-efficiency and quality and/or population health improvement goals and strategies for achieving return on investment.

Neither cost sharing nor matching are required for this project. However, applicants are encouraged to include in their application any participation by stakeholders in the community as an indicator of community and organizational support for the project and the likelihood that the project will continue after Federal support has ended. Such participation may be in the form of cash or in-kind (e.g., equipment, volunteer labor, building space, indirect costs, etc.).

Once able to demonstrate cost savings and return on investment, Beacon Communities may be receiving financial support from third party payers. It is anticipated that this program income will be substantial for all successful projects and essential for the projects' sustainability after the 36 month funding period. To support sustainability, ONC places no limits on the accrual of program income. All funds generated in this fashion can be retained by the recipient and used for the same purposes for which the project was funded (note: this is not to say that cost savings attributable to the program can be channeled directly back into the program. Program income is distinct from, but in many cases dependent on, cost savings accrued).

If applicable, Beacon Communities may also highlight in the Sustainability Plan any strategy that relies upon health plan supported outcome-based payments (e.g. pay for performance) to providers who are actively involved in Beacon Community's health IT-enabled improvement initiatives.

8. Collaborations and Letters of Commitment from Key Participating Organizations and Agencies

In accordance with Section 3011 of ARRA, Beacon Communities are expected to coordinate with other health information promotion activities in order to achieve program goals. In order to extend services to providers across geographic healthcare communities,

it will be essential for Beacon Communities to extend current Federal, state, and local efforts to advance health IT and exchange, not supplant them. As such, Beacon Communities should detail specifically their intent to coordinate with, not duplicate existing efforts (e.g., purchasing certified EHR technology for providers otherwise ineligible for health IT incentives and implementation assistance). In this section, the applicant should describe how the Beacon Community will utilize in a non-duplicative fashion, where locally available, the expertise and capabilities of practice networks supported by other Federal, state, and local agencies in a manner consistent with the achievement of community-wide goals, including:

- Ability/Intent to leverage other Federal and ONC health IT resources and programs, including the specific nature of involvement with the following, if applicable:
    - Regional Extension Center program
    - State Health Information Exchange program
    - VA Hospitals or Department of Defense sites (and more specifically, involvement with the Virtual Lifetime Electronic Record initiative)
    - Indian Health Service or State or Local Tribal Health site
    - Health Research and Services Administration grant programs
    - Centers for Medicaid and Medicare Services Demonstration projects
    - State Medicaid payment program
    - Medicare Quality Improvement Organization
    - Department of Agriculture and Department of Commerce broadband funding
    - Department of Agriculture telehealth funding
- Letter of support from State Health IT coordinator for all states within geographical area. Letters of support from Medicaid Directors or other Public Health Officials are also desirable, particularly if they are relevant to the chosen health improvement goal.
- Ability/Intent to leverage other community resources and programs:

In this section, applicants must include, at minimum, a letter of support from each community stakeholder. Applicable community stakeholders include, but are not limited to:

- State Primary Care Association(s)
- Health Professional Societies
- Health Center Controlled Networks (HCCNs) (for more information about HCCNs, go to: http://www.hrsa.gov/healthit/healthcenternetworks/default.htm)
- Health Plans

- Hospital Systems
- Community Colleges
- Universities and academic health centers
- Employers and employer groups
- Consumer groups

Beacon Community applications will be strengthened by inclusion of credible keystone Stakeholder organizations. Stakeholders with substantial involvement as reflected by staffing or financial commitment to their Beacon Community will naturally contribute more robustly than an organization which is committing only written support for the program's efforts. In order to evaluate the level of community-wide buy-in for the applicant's proposal, ONC requires submission of a Stakeholder Summary Matrix which details the specific nature of involvement and level of commitment of each stakeholder according to the following scale:

1 – Applicant has provided Letter of Support from Stakeholder detailing the nature of involvement with the Beacon Community.

2 – Applicant has provided Letter of Support from Stakeholder as above, and Budget Narrative for Beacon Community reflects financial commitment from the Stakeholder.

3 – Applicant has provided Letter of Support from Stakeholder as above, and Organizational Capability Statement includes specific commitment of senior-level executives to the Beacon Community leadership team.

4 – Applicant has provided Letter of Support from Stakeholder as above, Budget Narrative for Beacon Community reflects financial commitment from Stakeholder, and Organizational Capability Statement includes board-level, specific commitment of staff to the Beacon Community leadership team.

Please refer to Appendix I for a template of the Stakeholder Summary Matrix and instructions for its completion.

9. Nondiscrimination and Conflict of Interest Policies

This section describes the potential for any perceived conflict(s) of interest of the applicant(s), and the steps taken to demonstrate a commitment to transparent, fair, nondiscriminatory, and unbiased service to all primary care providers in the geographic service area. As part of the application package, applicants should provide certification that there is no conflict of interest, real or perceived, with health IT vendors (See Appendix E, Conflict of Interest Certification Template).

10. Budget Narrative/Justification

All applicants are required to outline proposed costs that support all project activities in the Budget Narrative/Justification. The application must include the allowable activities that will take place during the funding period and outline the estimated costs that will be used specifically in support of the program. Costs are

not allowed to be expended until the start date listed in the Notice of Grant Award. Whether direct or indirect, all costs must be allowable, allocable, reasonable and necessary under the applicable OMB Cost Circular: http://www.whitehouse.gov/omb/circulars (Circular A-87 for States and Circular A-122 for SDEs) and based on the programmatic requirements for administering the program as outlined in ARRA. See Appendix D for detailed information on completing the budget forms.

Awards will be made for a 36 month project period; the budget period will be equivalent to the project period. For purposes of preparing the budgets, applicants should note the following:

- Applicants must allocate sufficient funding for core activities, based on the size of the proposed geographic service area for the Beacon Community, the need for additional capital and other costs of capacity building, and variations in locality costs, for each year of each budget period.
- Any fees as program income to be used as specified in Section I.C.2 Use of Funds.

D. Submission Dates and Times

Applicants are required to submit a "Letter of Intent to Apply" for this funding opportunity. Letters of Intent to Apply must be submitted electronically, no later than 11:59 p.m. Eastern Standard Time on January 8, 2010. Letters of intent that fail to meet this due date will not be reviewed, and any future application for the Beacon Community Program by that organization will not be considered. Information on where to submit the Letter of Intent can be found in Section IV.A. Address to Request Application Package.

Applicants will be required to submit an application that will undergo screening for completeness and responsiveness and, if indicated, an objective review process. Applications must be submitted via grants.gov no later than 5:00 p.m. EST on February 1, 2010. Applications that fail to meet the application due date will not be reviewed and will receive no further consideration. Information on where to submit the Application can be found in Section IV.A. Address to Request Application Package.

Grants.gov will automatically send applicants a tracking number and date of receipt verification electronically once the application has been successfully received and validated. After the Office of Grants Management retrieves the application form from grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by grants.gov.

FOA Released	Letters of Intent Due	Applications Due	Cooperative Agreements Awarded	Anticipated Start Date
December 2, 2009	January 8, 2010 11:59 PM EST BeaconCommunity Grants@hhs.gov	February 1, 2010 5:00 PM EST http://www.grants.gov	March, 2010	April 1, 2010

E. Intergovernmental Review

This program is excluded from Executive Order 12372.

F. Funding Restrictions

ONC will, via program guidance, furnish potential applicants further information regarding allowable activities consistent with criteria to qualify for meaningful use incentive payments as established by the Secretary through notice-and-comment rulemaking.

Funds under this announcement cannot be used for the following purposes:

- To supplant or replace current public or private funding.
- To supplant on-going or usual activities of any organization involved in the project.
- To purchase or improve land, or to purchase, construct, or make permanent improvements to any building except for minor remodeling.
- To reimburse pre-award costs.

Funds are to be used in a manner consistent with program requirements as outlined in this FOA. Allowable administrative functions/costs include:

- Usual and recognized overhead, including indirect rates for all consortium organizations that have a Federally approved indirect cost rate; and
- Management and oversight of specific project components funded under this program.

V. Application Review Information

A. Application Review Criteria

The purpose of these Review Criteria shall be to select qualified Beacon Communities which have the leadership structure, community-wide investment, experience, and

advanced capabilities necessary to achieve high enough levels of meaningful use in the short term to demonstrate the feasibility of cost and quality improvements and, in so doing, promote the development of a nationwide health IT infrastructure built on the sustainable efforts of local providers and communities.

A panel that may include both expert peer reviewers and Federal staff will review each application that meets the responsiveness and screening criteria in Section IV.B Application Screening and Responsiveness Criteria. The purpose of this review is to determine if the approach and strategy are aligned with program requirements. The detailed results of this review will be shared with the applicant upon request. Additionally, the review results will form the basis for development of the programmatic terms and conditions of the cooperative agreement.

Each application will be scored according to the following point system:

Health Information Technology and Exchange Infrastructure [20 total points available]

Criteria for full awarding of points:

- Community has baseline EHR adoption rate of at least 40% among physicians and 20% among hospitals[8] in the community and proposal details credible method for deriving estimates; and
- For those Communities that intend to purchase certified EHR technology, support is limited to providers who are ineligible for meaningful use incentive payments under Medicare and/or Medicaid, in accordance with Section 3011 of ARRA; and
- Community does not intend to extend funds proposed to accelerate the adoption of EHR systems through the purchase of certified EHR software to providers who are, or who will become, eligible for meaningful use incentive payments; and
- Existing HIE services relevant to meaningful use and necessary for care coordination are utilized by at least 20% of providers and proposal details plan to extend these services to all community providers during the performance period; and
- Applicant has partnered, or plans to partner, with ONC funded State HIE efforts; and
- Proposal details a strong, credible, and feasible plan to supplement existing efforts to advance meaningful use in the community and promote advanced health IT functionalities such as Clinical Decision Support, disease

[8] These EHR adoption rates were selected by ONC after consideration of a) 2007 rates of EHR adoption (DesRoches CM, Campbell EG, Rao SR et al. Electronic Health Records in Ambulatory Care – A National Survey of Physicians. *N Engl J Med* 2008;359:50-60.) and b) the advanced level of health IT infrastructure required to achieve adoption of certified EHRs among 60% of primary care physicians by the end of FY 2012.

monitoring/management, data aggregation, and quality and public health reporting, as well as partnership with an ONC funded regional health information extension center (objective review panel can choose to waive requirement for collaboration with regional center if rate of adoption and meaningful use is greater than 50% among all providers); and

- Health IT systems proposed for purchase can achieve standards-based interoperability consistent with meaningful use specifications; and
- Community includes VLER site, Federally funded broadband initiative, Indian Health Service facility and/or HRSA funded health IT initiative.

Integration of Health Information Technology Into Care Delivery [15 total points available]

Criteria for full awarding of points:

- Established and demonstrated excellence in the area of practice redesign and care coordination, as evidenced by the success of previous and/or existing care coordination, workflow and/or process redesign, quality improvement, and/or health outcomes improvement initiatives; and
- Presented a strong, credible, and feasible plan to expand existing care coordination capabilities utilize Program funding to integrate health IT into care delivery to reach proposed quality and/or population health improvement goals by end of FY 2012; and
- Demonstrated understanding of the central importance of health IT infrastructure for enabling and sustaining process redesign and health outcomes improvement.

Evaluation, Performance Monitoring and Feedback [15 total points available]

Criteria for full awarding of points:

- Established and demonstrable excellence in the area of evaluation, performance monitoring and feedback, including:
    - Strength of experience in performance measurement and feedback (e.g., existing public reporting of practice-level quality measures); and
    - Success of previous and/or ongoing cost-efficiency improvement initiatives (e.g., reduction of preventable hospitalizations, prevention of hospital readmissions, reduction of emergency room visits, improvement in medication therapy management, efficiency improvements, reduction in redundant and inappropriate diagnostic services, and prevention of hospital-acquired conditions); and

- Strong project plan to advance health IT infrastructure to enable achievement cost-efficiency improvement goals by end of FY2012.

Strength and Scope of Project [45 total points available in the following areas]
Criteria for full awarding of points:

1. **Project proposal [10 points available]**

    - Priority area(s) proposed by the applicant is/are well-justified, important, specific and measurable and meet(s) the objectives of the Beacon Community program as outlined in the FOA; and
    - Proposal includes especially strong strategy for leveraging other Federal resources, including but not limited to ONC funded regional centers and State HIE initiatives, VLER, HRSA Federally qualified health centers or health center controlled networks, IHS facilities, Federally funded Broadband initiatives, and HRSA health IT grant programs; and
    - Applicant has strong likelihood of demonstrating expected cost-efficiency, quality, and/or population health improvements; and
    - Proposal emphasizes and demonstrates central and specific role of health IT in accomplishing project objectives; and
    - Project is community-based and involves multi-modal intervention for priority areas; and
    - Proposal outlines plan for integration of the three areas (Health IT and Exchange Infrastructure, Integration of Health Information Technology into Care Delivery, and Evaluation, Performance Monitoring and Feedback (as defined in specific area criteria in Section V.A)).

2. **Sustainability Plan [5 points available]**
    - Sustainability plan includes commitments from community stakeholders (government, purchasers, and payers) to participate in Beacon Community activities after Federal support has ended. Such participation may be in the form of cash or in-kind (e.g., equipment, volunteer labor, building space, indirect costs, etc); and
    - Sustainability plan details linkage to existing payment pilots or multi-payer collaboratives (e.g., quality reporting initiatives, patient-centered medical home, and bundled payments) or plans to achieve these linkages within the first year of funding in order to generate adequate program income to sustain Beacon Community activities after the 36 month funding period.

3. **Organizational Capacity [15 points available]**
   a. **Project Leadership (10 points available)**
      - Stakeholder Summary Matrix shows Level 4 Commitment by creditable community organization with experience relevant to health IT enabled health outcome and/or cost savings goal(s) (See Section IV.C.8. Collaborations and Letters of Commitment from Key Participating Organizations and Agencies); and
      - Organizational Capacity demonstrates experienced, exceptionally strong project leadership, including executive sponsorship, governance structures and functions, decision making processes, dedicated coordinator and point of contact for the project; and
      - The project management structure and design will enable accountability; and
      - The leadership team includes patient/consumer representative or member of a patient/consumer advocacy group.

   b. **Multi-Stakeholder Commitment (5 points available)**
      - Active engagement and commitment from political leaders, the State HIT Coordinator, the State Medicaid Director and relevant public health agencies on a city, county or state level; and
      - Existing multi-stakeholder collaboration to promote health IT, improve community health, and/or enable quality reporting, with participants that include, but are not limited to: primary care providers (PCPs), practicing clinicians, hospitals, public and private payers, consumers, local and state public health departments, safety net providers, employers, academic institutions, charitable foundations, industry, laboratories, pharmacies, employers, quality improvement organizations, hospital associations, government entities, and medical societies.

4. **Geographic and Community Diversity [5 points available]**
   The application review and selection process will ensure that a geographically diverse set of communities are awarded cooperative agreements. Specifically, at least five communities are expected to be located in or include substantial rural areas.
      - Diverse care settings (e.g., small practice, community health center, rural health clinic, long term care, tertiary hospital) along established patterns of care

- Inclusion of safety net providers (Community Health Center Controlled Networks, Federally Qualified Health Centers, IHS facilities, providers with high volume Medicaid and uninsured populations)
- Opportunities for participation by rural hospitals and clinics
- Involvement of underserved or minority populations
- Involvement of care settings for veteran populations (applicant must include the number of providers contracted to provide care for military personnel and veterans in the community)

5. **Opportunity to leverage and concentrate state and Federal assets [10 points available]**
   Proposal includes existing relationship(s) or strategy for involvement of the following entities (proposals will be scored according to strength and number of the existing relationships and/or strategies):
   - ONC funded Regional Extension Center
   - ONC funded State Health Information Exchange program
   - DoD and VA facility in concert with the VLER
   - HRSA EHR, health IT and workforce grant programs
   - Federally funded broadband access program
   - Indian Health Service telehealth program
   - ARRA funded Comparative Effectiveness Research initiative

Reasonableness of project budget (includes detailed description of allowable costs) [5 points available]

B. Review and Selection Process

Complete and FOA responsive applications will be evaluated for scientific and technical merit. HHS ONC will convene an objective review panel of area experts in accordance with HHS objective review procedures using the review criteria in Section V Application Review Information.

As part of the objective review, all applications will:

- be independently reviewed and scored according to Section V Application Review Information; and
- receive a written critique.

The following will be considered in making funding decisions:

- merit of the proposed project as determined by objective review;
- availability of funds; and
- relevance of the proposed project in relation to program priorities including geographic diversity and coverage of underserved areas.

VI. Award Administration Information

A. Award Notices

Each applicant will receive notification of the outcome of the review process outlined in Section V. Application Review Information, including whether the application was selected for funding. The lead applicant of each Beacon Community application selected for funding will be required to accept the terms and conditions placed on their application before funding can proceed. Letters of notification acknowledge that an award was funded, but do not provide authorization for the applicant to begin performance and expend funds associated with the award until the start date of the award as indicated in the notice. Applicants may request a summary of the expert committee's assessment of the application's merits and weaknesses.

The Notice of Grant Award (NGA) contains details on the amount of funds awarded, the terms and conditions of the cooperative agreement, the effective date of the award, the budget period for which support will be given, and the total project period timeframe. This NGA is then signed by the ONC Grants Management Officer, sent to the applicant agency's Authorized Representative, and will be considered the official authorizing document for this award. It will be sent to applicants prior to the anticipated start date of this program, April 1, 2010.

Successful applicants will receive an electronic NGA. Unsuccessful applicants are notified within 30 days of the final funding decision and will receive a disapproval letter via e-mail or U.S. mail.

B. Administrative and National Policy Requirements

The award is subject to HHS Administrative Requirements, which can be found in 45 CFR Part 74 (non-governmental) and 92 (governmental) and the Standard Terms and Conditions implemented through the HHS Grants Policy Statement located at http://www.hhs.gov/grantsnet/adminis/gpd/index.htm.

HHS Grants Policy Statement

ONC awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable to the grant/cooperative agreement based on recipient type and purpose of award. This includes, as applicable, any requirements in Parts I and II of the HHS GPS that apply to the award, as well as any requirements of Part IV. The HHS GPS is available at http://www.hhs.gov/grantsnet/adminis/gpd/. The general terms and conditions in

the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specifi

Recipients generally must retain financial and programmatic records, supporting documents, statistical records, and all other records that are required by the terms of an award, or may reasonably be considered pertinent to a grant/cooperative agreement, fo c requirements to the contrary (as specified in the Notice of Award).

Records Retention

r a period of three years from the date the final annual Financial Status Report (FSR) is submitted and approved. For awards where the FSR is submitted at the end of the competitive segment, the three-year retention period will be calculated from the date the FSR for the entire competitive segment is submitted. Those recipients must retain the records pertinent to the entire competitive segment for three years from the date the FSR is submitted and approved. See 45 CFR 74.53 and 92.42 for exceptions and qualifications to the three-year retention requirement (e.g., if any litigation, claim, financial management review, or audit is started before the expiration of the three-year period, the records must be retained until all litigation, claims, or audit findings involving the records have been resolved and final action taken). Those sections also specify the retention period for other types of award-related records, including indirect cost proposals and property records. See 45 CFR 74.48 and 92.36 for record retention and access requirements for contracts under grants/cooperative agreements.

C. Reporting

All reporting requirements will be provided to applicants of successful full applications, adherence to which is a required condition of any award. In general, the successful applicant under this guidance must comply with the following reporting and review activities:

a. Audit Requirements

The recipient shall comply with audit requirements of OMB Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at http://www.whitehouse.gov/omb/circulars;

b. Financial Status Reports

The recipient shall submit an annual Financial Status Report. An FSR is due no later than 90 days after the end of the applicable 12 month period and failure to submit these timely could affect future funding. Until HHS has migrated to the SF 425 FFR, award recipients will utilize the SF 269 FSR. The report is an accounting of expenditures under the project that year. More specific information on this reporting requirement will be included in the Notice of Grant Award.

c. ARRA-Specific Reporting

Quarterly Financial and Programmatic Reporting: Consistent with ARRA emphasis on accountability and transparency, reporting requirements under ARRA programs will differ from and expand upon HHS's standard reporting requirements for grants. In particular, section 1512(c) of ARRA sets out detailed requirements for quarterly reports that must be submitted within 10 days of the end of each calendar quarter. Receipt of funds will be contingent on meeting ARRA reporting requirements.

Information from recipient reports will be posted on a public website. To the extent that funds are available to pay a recipient's administrative expenses, those funds may be used to assist the recipient in meeting the accelerated time-frame and extensive reporting requirements of ARRA.

Additional instructions and guidance regarding required reporting will be provided as they become available. For planning purposes, however, all applicants shall be aware that ARRA section 1512(c) provides as follows:

Recipient Reports: Not later than 10 days after the end of each calendar quarter, each recipient that received recovery funds from a Federal agency shall submit a report to that agency that contains—

(1) the total amount of recovery funds received from that agency;

(2) the amount of recovery funds received that were expended or obligated to projects or activities; and

(3) a detailed list of all projects or activities for which recovery funds were expended or obligated, including--

(A) the name of the project or activity;

(B) a description of the project or activity;

(C) an evaluation of the completion status of the project or activity;

(D) an estimate of the number of jobs created and the number of jobs retained by the project or activity; and

(E) for infrastructure investments made by State and local governments, the purpose, total cost, and rationale of the agency for funding the infrastructure investment with funds made under this Act, and name of the person to contact at the agency if there are concerns with the infrastructure investment.

(4) Detailed information on any subcontracts or subgrants awarded by the recipient to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 (Public Law 109-282), allowing aggregate reporting on awards below $25,000 or to individuals, as prescribed by the Director of OMB. OMB guidance for implementing and reporting ARRA activities can be found at http://www.whitehouse.gov/omb/recovery_default/.

To assist in fulfilling the accountability objectives of ARRA, as well as the Department's responsibilities under the Government Performance and Results Act of 1993 (GPRA),

Public Law 103-62, applicants who receive funding under this program must provide data that measure the results of their work. Performance measures include the number of jobs saved and jobs created due to ARRA Funding. Additionally, applicants must discuss their data collection methods in the application.

Tutorials for the required quarterly recipient reports under ARRA can be found on the federalreporting.gov downloads website,https://www.federalreporting.gov/federalreporting/downloads.do

d. Program Reporting

Each award recipients will report annual progress on EHR adoption and HIE among providers in their community. In addition, they will report annually on the proportion of primary care physicians qualifying for Medicare and Medicaid meaningful use incentives.

D. Cooperative Agreement Terms and Conditions of Award

This section details the specific terms and conditions applicable to successful awarding of full applications, not preliminary applications. Upon award of a cooperative agreement, the following special terms of award are in addition to, and not in lieu of, otherwise applicable OMB administrative guidelines, HHS grant administration regulations at 45 CFR Parts 74 and 92, and other HHS, PHS, and ONC grant administration policies.

The administrative and funding instrument used for this program will be the cooperative agreement, in which substantial ONC programmatic involvement with the recipients is anticipated during the performance of the activities. Under the cooperative agreement, the ONC purpose is to support and stimulate recipients' activities by involvement in and otherwise working jointly with the award recipients in a partnership role; it is not to assume direction, prime responsibility, or a dominant role in the activities. Consistent with this concept, the dominant role and prime responsibility resides with the recipients for the project as a whole, although specific tasks and activities may be shared among recipients and ONC as defined below. To facilitate appropriate involvement, during the period of this cooperative agreement, ONC and the recipient will be in contact monthly and more frequently when appropriate. Requests to modify or amend the cooperative agreement or the work plan may be made by ONC or the recipient at any time. Modifications and/or amendments to the cooperative agreement or work plan shall be effective upon the mutual agreement of both parties, except where ONC is authorized under the Terms and Conditions of award, 45 CFR Part 74 or 92, or other applicable regulation or statute to make unilateral amendments.

1. Cooperative Agreement Roles and Responsibilities

a. Office of the National Coordinator for Health Information Technology (ONC)

ONC will have substantial involvement in program awards, including, but not limited to the elements outlined below:

- Technical Assistance – This includes, but is not limited to, Federal guidance on a variety of issues related to program implementation.
- Collaboration – To facilitate compliance with the terms of the cooperative agreement and to more effectively support recipients, ONC will actively coordinate with critical stakeholders, including recipients of ONC cooperative agreements under Section 3011 of the PHSA as amended by ARRA, Federal and State agencies, regional centers, and HITRC as needed. This includes, but is not limited to, working with each Beacon Community in a collaborative manner to refine the Community's proposed quality, cost-efficiency, and population health improvement goals and metrics;
- Project Officers – ONC will assign specific Project Officers to each cooperative agreement award to support and monitor recipients throughout the project period.
- Conference and Training Opportunities – ONC will provide opportunities for training and/or networking, via the National Learning Consortium facilitated by the HITRC.
- Extending Beacon's Reach – ONC will aid Beacon Communities in dissemination of best practices through the Health Information Technology Research Center.
- Monitoring – ONC Project Officers will monitor, on a regular basis, progress of each recipient. This monitoring may be by phone, document review, on-site visit, other meeting and by other appropriate means, such as reviewing program progress reports and Financial Status Reports (SF269). This monitoring will be to determine compliance with programmatic and financial requirements.
- Evaluation – ONC will facilitate and oversee an external evaluation of the program.

b. Recipients

Recipients and assigned points of contact retain the primary responsibility and dominant role for planning, directing and executing the proposed project as outlined in the terms and conditions of the Cooperative Agreement and with substantial ONC involvement. Responsibilities include:

- Requirements – Recipients shall comply with all current and future requirements of this FOA, future ONC program guidance, the terms and conditions of the Award Notice, and any other requirement specified and approved by the Secretary.
- Collaboration -- Recipients are required to collaborate with the critical stakeholders listed in this FOA and the ONC team and ONC supported initiatives, including but not limited to, cooperative agreements under Section 3011 of the PHSA as added by ARRA.
- Reporting – Recipients are required to comply with all reporting requirements outlined in this FOA and the terms and conditions of the cooperative agreement to ensure the timely release of funds.
- Program Evaluation – Recipients are required to cooperate with the ONC-directed biennial evaluation.

E. American Recovery and Reinvestment Act of 2009

HHS Standard Terms and Conditions

HHS award recipients must comply with all terms and conditions outlined in their award, including policy terms and conditions contained in applicable HHS Grant Policy Statements, and requirements imposed by program statutes and regulations and HHS grant administration regulations, as applicable, unless they conflict or are superseded by the following terms and conditions implementing the American Recovery and Reinvestment Act of 2009 (ARRA) requirements below. In addition to the standard terms and conditions of award, recipients receiving funds under Division A of ARRA must abide by the terms and conditions set out below. The terms and conditions below concerning civil rights obligations and disclosure of fraud and misconduct are reminders rather than new requirements, but the other requirements are new and are specifically imposed for awards funded under ARRA. Recipients are responsible for contacting their HHS grant/program managers/project officers for any needed clarifications.

Awards issued under this FOA are also subject to the requirements set forth in Section 3011 of the PHSA, as added ARRA.

a. Preference for Quick Start Activities

In using funds for this award for infrastructure investment, recipients shall give preference to activities that can be started and completed expeditiously, including a goal of using at least 50 percent of the funds for activities that can be initiated not later than 120 days after the date of the enactment of ARRA. Recipients shall also use funds in a manner that maximizes job creation and economic benefit. (ARRA Sec. 1602)

b. Limit on Funds

None of the funds appropriated or otherwise made available in ARRA may be used by any state or local government, or any private entity, for any casino or other gambling establishment, aquarium, zoo, golf course, or swimming pool. (ARRA Sec. 1604)

c. ARRA: One-Time Funding

Unless otherwise specified, ARRA funding to existent or new recipients should be considered one-time funding.

d. Civil Rights Obligations

In conducting activities under any cooperative agreement executed as recipients have civil rights obligations under Federal law, as referenced in the HHS Grants Policy Statement. Recipients and sub-recipients of ARRA funds or other Federal financial assistance must comply with Title VI of the Civil Rights Act of 1964 (prohibiting race, color, and national origin discrimination), Section 504 of the Rehabilitation Act of 1973 (prohibiting disability discrimination), Title IX of the Education Amendments of 1972 (prohibiting sex discrimination in education and training programs), and the Age Discrimination Act of 1975 (prohibiting age discrimination in the provision of services). For further information and technical assistance, please contact the HHS Office for Civil Rights at (202) 619-0403, OCRmail@hhs.gov, or http://www.hhs.gov/ocr/civilrights/.

e. Disclosure of Fraud or Misconduct

Each recipient or sub-recipient awarded funds made available under ARRA shall promptly refer to the HHS Office of Inspector General any credible evidence that a principal, employee, agent, contractor, sub-recipient, subcontractor, or other person has submitted a false claim under the False Claims Act or has committed a criminal or civil violation of laws pertaining to fraud, conflict of interest, bribery, gratuity, or similar misconduct involving those funds. The HHS Office of Inspector General can be reached at http://www.oig.hhs.gov/fraud/hotline/.

f. Responsibilities for Informing Sub-recipients

Recipients agree to separately identify to each sub-recipient, and document at the time of sub-award and at the time of disbursement of funds, the Federal award number, any special CFDA number assigned for ARRA purposes, and amount of ARRA funds.

g. ARRA Transactions listed in Schedule of Expenditures of Federal Awards and Recipient Responsibilities for Informing Sub-recipients

(a) To maximize the transparency and accountability of funds authorized under ARRA as required by Congress and in accordance with 45 CFR 74.21 and 92.20 "Uniform Administrative Requirements for Grants and Agreements", as applicable, and OMB A-102 Common Rules provisions, recipients agree to maintain records that identify adequately the source and application of ARRA funds.

(b) For recipients covered by the Single Audit Act Amendments of 1996 and OMB Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations," recipients agree to separately identify the expenditures for Federal awards under ARRA on the Schedule of Expenditures of Federal Awards (SEFA) and the Data Collection Form (SF-SAC) required by OMB Circular A-133. This shall be accomplished by identifying expenditures for Federal awards made under ARRA separately on the SEFA, and as separate rows under Item 9 of Part III on the SF-SAC by CFDA number, and inclusion of the prefix "ARRA-" in identifying the name of the Federal program on the SEFA and as the first characters in Item 9d of Part III on the SF-SAC.

(c) Recipients agree to separately identify to each sub recipient, and document at the time of sub-award and at the time of disbursement of funds, the Federal award number, CFDA number, and amount of ARRA funds. When a recipient awards ARRA funds for an existing program, the information furnished to sub-recipients shall distinguish the sub-awards of incremental ARRA funds from regular sub-awards under the existing program.

(d) Recipients agree to require their sub-recipients to include on their SEFA information to specifically identify ARRA funding similar to the requirements for the recipient SEFA described above. This information is needed to allow the recipient to properly monitor sub-recipient expenditure of ARRA funds as well as oversight by the Federal awarding agencies, Offices of Inspector General and the Government Accountability Office.

h. Recipient Reporting

Reporting and Registration Requirements under Section 1512 of ARRA.

(a) This award requires the recipient to complete projects or activities which are funded under ARRA and to report on use of ARRA funds provided through this award. Information from these reports will be made available to the public.

(b) The reports are due no later than 10 calendar days after each calendar quarter in which the recipient receives the assistance award funded in whole or in part by ARRA.

(c) Recipients and their first-tier recipients must maintain current registrations in the Central Contractor Registration (http://www.ccr.gov) at all times during which they have active Federal awards funded with ARRA funds. A Dun and Bradstreet Data Universal Numbering System (DUNS) Number (http://www.dnb.com) is one of the requirements for registration in the Central Contractor Registration.

(d) The recipient shall report the information described in section 1512(c) using the reporting instructions and data elements that will be provided online at http://www.FederalReporting.gov and ensure that any information that is pre-filled is corrected or updated as needed.

(e) Guidance for adhering to ARRA Reporting Requirements is addressed in an OMB Memorandum issued June 22, 2009: http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-21.pdf. Applicants are required to adhere to all of these reporting requirements, as well as future requirements as issued by OMB.

VII. Agency Contacts

Program Contact:

Beacon Community Program

Office of the National Coordinator for Health Information Technology

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This funding announcement is subject to restrictions on oral conversations during the period of time commencing with the submission of a formal application by an individual or entity and ending with the award of the competitive funds. Federal officials may not participate in oral communications initiated by any person or entity concerning a pending application for a Recovery Act competitive grant or other competitive form of Federal financial assistance, whether or not the initiating party is a Federally registered lobbyist. This restriction applies unless:

(i) the communication is purely logistical;

(ii) the communication is made at a widely attended gathering;

(iii) the communication is to or from a Federal agency official and another Federal Government employee;

(iv) the communication is to or from a Federal agency official and an elected chief executive of a state, local or tribal government, or to or from a Federal agency official and the Presiding Officer or Majority Leader in each chamber of a state legislature; or

(v) the communication is initiated by the Federal agency official.

For additional information see http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-24.pdf .

VIII. Other Information: Appendices

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A. Appendix A – Statutory Text for Beacon Community Program

SEC. 3011. IMMEDIATE FUNDING TO STRENGTHEN THE HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE.

(a) In General- The Secretary of Health and Human Services shall, using amounts appropriated under section 3018, invest in the infrastructure necessary to allow for and promote the electronic exchange and use of health information for each individual in the United States consistent with the goals outlined in the strategic plan developed by the National Coordinator (and, as available) under section 3001. To the greatest extent practicable, the Secretary shall ensure that any funds so appropriated shall be used for the acquisition of health information technology that meets standards and certification criteria adopted before the date of the enactment of this title until such date as the standards are adopted under section 3004. The Secretary shall invest funds through the different agencies with expertise in such goals, such as the Office of the National Coordinator for Health Information Technology, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the Centers of Medicare & Medicaid Services, the Centers for Disease Control and Prevention, and the Indian Health Service to support the following:

(1) Health information technology architecture that will support the nationwide electronic exchange and use of health information in a secure, private, and accurate manner, including connecting health information exchanges, and which may include updating and implementing the infrastructure necessary within different agencies of HHS to support the electronic use and exchange of health information.

(2) Development and adoption of appropriate certified electronic health records for categories of providers not eligible for support under title XVIII or XIX of the Social Security Act for the adoption of such records.

(3) Training on and dissemination of information on best practices to integrate health information technology, including electronic health records, into a provider's delivery of care, consistent with best practices learned from the Health Information Technology Research Center developed under section 3012, including community health centers receiving assistance under section 330 of the Public Health Service Act, covered entities under section 340B of such Act, and providers participating in one or more of the programs under titles XVIII, XIX, and XXI of the Social Security Act (relating to Medicare, Medicaid, and the State Children's Health Insurance Program).

(4) Infrastructure and tools for the promotion of telemedicine, including coordination among Federal agencies in the promotion of telemedicine.

(5) Promotion of the standards-based interoperability of clinical data repositories or registries.

(6) Promotion of technologies and best practices that enhance the protection of health information by all holders of individually identifiable health information.

(7) Improve and expand the use of health information technology by public health departments.

(8) Provide $300,000,000 to support regional or sub-national efforts towards HIE.

(b) Coordination- The Secretary shall ensure funds under this section are used in a coordinated manner with other health information promotion activities.

(c) Additional Use of Funds- In addition to using funds as provided in subsection (a), the Secretary may use amounts appropriated under section 3018 to carry out activities that are provided for under laws in effect on the date of enactment of this title.

SEC. 3017. GENERAL GRANT AND LOAN PROVISIONS.

(a) Reports- The Secretary may require that an entity receiving assistance under this subtitle shall submit to the Secretary, not later than the date that is 1 year after the date of receipt of such assistance, a report that includes—

(1) an analysis of the effectiveness of the activities for which the entity receives such assistance, as compared to the goals for such activities; and

(2) an analysis of the impact of the project on health care quality and safety.

(b) Requirement to Improve Quality of Care and Decrease in Costs- The National Coordinator shall annually evaluate the activities conducted under this subtitle and shall, in awarding grants, implement the lessons learned from such evaluation in a manner so that awards made subsequent to each such evaluation are made in a manner that, in the determination of the National Coordinator, will result in the greatest improvement in the quality and efficiency of health care.

B. Appendix B – Illustrations of the Beacon Community Concept

Hypothetical Community 1 plans to achieve near-universal health IT adoption and improved diabetes outcomes and reduced cost through improved care coordination.

Total Costs ~ $19.5 million over 2.5 year project period

- Project coordination: 15 staff and associated costs (legal, outreach, etc)- **$3 million**
- Health IT infrastructure: Hardware, software, networking, and IT services valued at 20k per provider (physician or other individual provider) x 300 providers (who are not eligible for health IT incentive payments and have not already adopted)- **$6 million**
- Performance monitoring and feedback services: Data collection, analytics, benchmarking, and feedback tools- **$1.5 million**
- Technical assistance for practice redesign and care coordination (decision support, panel management, planned visits, patient engagement, medication management): 15 k per provider x 600 providers- **$9 million**

Hypothetical Community 2 plans to leverage an existing robust health IT infrastructure to institute a care coordination effort through telemedicine for 2500 patients with congestive heart failure. This community intends to improve adherence with medication guidelines, patient health outcomes and functionality; and lower readmission rates, length of stay and costs.

Costs ~ $ 20 million over a 2.5 year project period

- Project coordination: 15 staff and associated costs (legal, outreach, etc)- **$3 million**
- Health IT infrastructure: Telemedicine equipment - $3K/ per patient x 2500 patients = **$7.5 million**
- Performance monitoring and feedback services: data collection, analytics, benchmarking, and feedback tools- **$1.5 million**
- Care coordination through telemedicine: Treatment planning, disease and medication management services, telemonitoring, education for patients and families, and support groups, provided by 30 staff including clinicians, nurses and care coordinators - **$8 million**

C. Appendix C – Priority Grants Programs Background

On February 17, 2009, the President signed the American Recovery and Reinvestment Act of 2009 (ARRA). This statute includes The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) that sets forth a plan for advancing the appropriate use of health information technology to improve quality of care and establish a foundation for health care reform. ONC was statutorily established by the HITECH Act within HHS. ONC serves as the principal Federal entity charged with coordinating the overall effort to implement a nationwide health information technology infrastructure that allows for the use and exchange of health information in electronic format.

The HITECH Act authorizes the Centers for Medicare & Medicaid Services (CMS) to administer incentives to eligible professionals (EPs) and hospitals for meaningful use of electronic health records (EHRs). It is anticipated these incentives will accelerate adoption of EHRs needed to reach the goal of all Americans having a secure EHR. To achieve the vision of a transformed health system that health information technology (HIT) can facilitate, there are three critical short-term prerequisites:

- Clinicians and hospitals must acquire and implement certified EHRs in a way that fully integrates these tools into the care delivery process;
- Technical, legal, and financial supports are needed to enable information to flow securely to wherever it is needed to support health care and population health; and,
- A skilled workforce needs to support the adoption of EHRs, information exchange across health care providers and public health authorities, and the redesign of work-flows within health care settings to gain the quality and efficiency benefits of EHRs, while maintaining individual privacy and security.

Priority Programs. The HITECH Act also authorizes the establishment of several new grant programs that will provide resources to address these prerequisites. Together, they are expected to facilitate the adoption and effective use of EHRs by providing technical assistance, the capacity to exchange health information, and the availability of trained professionals to support these activities. These priority grant programs are:

- Health Information Technology Extension Program (Extension Program), authorized by PHSA Section 3012, as added by ARRA - will establish a collaborative consortium of Health Information Technology Regional Extension Centers (Regional Centers) facilitated by the national Health Information Technology Research Center (HITRC). The Extension Program will offer providers across the nation technical assistance in the selection, acquisition, implementation, and meaningful use of an EHR to improve health care quality and outcomes. (*The Extension Program's Regional Centers are the topic of this Funding Opportunity Announcement.)*
- State Grants to Promote Health Information Technology (State Health Information Exchange Cooperative Agreements Program), authorized by PHSA

Section 3013, as added by ARRA - to promote HIE that will advance mechanisms for information sharing across the health care system.

- Information Technology Professionals in Health Care (Workforce Program), authorized by PHSA Section 3016, as added by ARRA - to fund the training and development of a workforce that will meet short-term HITECH Act programmatic needs.

D. Appendix D – Instructions for Completing the Required Budget Forms

This section provides step-by-step instructions for completing the standard Federal forms required as part of your application, including special instructions for completing Standard Forms SF-424 – Application for Federal Assistance, 424A – Budget Information for Non-Construction Programs, and 424B – Assurances for Non-Construction Programs. These Standard Forms are used for a wide variety of Federal grant programs, and Federal agencies have the discretion to require some or all of the information on these forms. Accordingly, please use the instructions below in lieu of the standard instructions attached to SF- 424 and SF-424A to complete these forms.

Standard Form 424 – Application for Federal Assistance

1. **Type of Submission:** (Required): Select one type of submission in accordance with agency instructions: • Preliminary Application, • Application, • Changed/Corrected Application – If requested (check if this submission is to change or correct a previously submitted application).
2. **Type of Application:** (Required) Select: • New.
3. **Date Received:** Leave this field blank.
4. **Applicant Identifier:** Leave this field blank.
5. **A) Federal Entity Identifier:** Leave this field blank.
   B) Federal Award Identifier: For new applications leave blank.
6. **Date Received by State:** Leave this field blank.
7. **State Application Identifier:** Leave this field blank.
8. **Applicant Information:** Enter the following in accordance with agency instructions:
   a. **Legal Name:** (Required): Enter the name that the organization has registered with the Central Contractor Registry. Information on registering with CCR may be obtained by visiting the grants.gov website.
   b. **Employer/Taxpayer Number (EIN/TIN):** (Required): Enter the Employer or Taxpayer Identification Number (EIN or TIN) as assigned by the Internal Revenue Service.
   c. **Organizational DUNS:** (Required) Enter the organization's DUNS or DUNS+4 number received from Dun and Bradstreet.
   d. **Address:** (Required) Enter the complete address including the county.
   e. **Organizational Unit:** Enter the name of the primary organizational unit (and department or division, if applicable) that will undertake the project.
   f. **Name and contact information of person to be contacted on matters involving this application:** Enter the name (First and last name required), organizational affiliation (if affiliated with an organization other than the applicant organization), telephone number (Required), fax number, and email address (Required) of the person to contact on matters related to this application.

9. **Type of Applicant:** (Required) Self-identify the applicant organization "type" from the drop down list.
10. **Name of Federal Agency:** (Required) Enter Office of the National Coordinator for Health Information Technology (ONC)
11. **Catalog of Federal Domestic Assistance Number/Title:** Enter 93.727
12. **Funding Opportunity Number/Title:** (Required) The Funding Opportunity Number is ##-####. The title of the opportunity is Beacon Community Program.
13. **Competition Identification Number/Title:** Leave this field blank.
14. **Areas Affected By Project:** List the largest political entity affected (cities, counties, state, etc).
15. **Descriptive Title of Applicant's Project:** (Required) Enter a brief descriptive title of the project.
16. **Congressional Districts Of:** (Required)
    a. Enter the applicant's Congressional District
    b. Enter all district(s) affected by the program or project. Enter in the format: 2 characters State Abbreviation – 3 characters District Number, e.g., CA-005 for California 5th district, CA-012 for California 12th district, NC-103 for North Carolina's 103rd district. • If all congressional districts in a state are affected, enter "all" for the district number, e.g., MD-all for all congressional districts in if Maryland. • If nationwide, i.e. all districts within all states are affected, enter US-all.
17. **Proposed Project Start and End Dates:** (Required) April 1, 2010 – March 31, 2013.
18. **Estimated Funding:** (Required) Enter the amount requested or to be contributed during each funding/budget period by each contributor. Value of in-kind contributions should be included on appropriate lines, as applicable. If the action will result in a dollar change to an existing award, indicate only the amount of the change. For decreases, enclose the amounts in parentheses.

    NOTE: Applicants should review cost sharing principles contained in Subpart C of 45 CFR Part 74 or 45 CFR Part 92 before completing Item 18 and the Budget Information Sections A, B and C of the SF-424A noted below.

    All budget information entered under item 18 should cover the entire three-year period of support. For sub-item 18a, enter the Federal funds being requested.

    NOTE: Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. **Indirect charges** may only be requested if: (1) the applicant has a current indirect cost rate agreement approved HHS or another Federal agency; or (2) the applicant is a state or local government agency. State governments should enter the amount of indirect costs determined in accordance with HHS requirements. **If indirect costs are to be included in the application, a copy of the approved indirect cost agreement must be included with the application. Further, if any sub-contractors or sub-grantees are requesting indirect costs, copies of their indirect cost agreements must also be included with the application.**

19. **Is Application Subject to Review by State Under Executive Order 12372 Process?** Check c. Program is not covered by E.O. 12372

20. **Is the Applicant Delinquent on any Federal Debt?** (Required) This question applies to the applicant organization, not the person who signs as the authorized representative. If yes, include an explanation on the continuation sheet.

21. **Authorized Representative:** (Required) To be signed and dated by the authorized representative of the applicant organization. Enter the name (First and last name required) title (Required), telephone number (Required), fax number, and email address (Required) of the person authorized to sign for the applicant. A copy of the governing body's authorization for you to sign this application as the official representative must be on file in the applicant's office.

Standard Form 424A – Budget Information for Non-Construction Program

NOTE: Standard Form 424A is designed to accommodate applications for multiple grant programs; thus, for purposes of this program, many of the budget item columns and rows are not applicable. You should only consider and respond to the budget items for which guidance is provided below. The SF-424A should reflect the three-year project/budget period.

Section A - Budget Summary

Line 5: Leave columns (c) and (d) blank. Enter TOTAL Federal costs in column (e) and total non-Federal costs (including third party in-kind contributions and any program income to be used as part of the grantee cost share contribution) in column (f). Enter the sum of columns (e) and (f) in column (g).

Section B - Budget Categories

Column 3: Enter the breakdown of how you plan to use the Federal funds being requested by object class category (see instructions for each object class category below).

Column 4: Enter the breakdown of how you plan to use the non-Federal share by object class category.

Column 5: Enter the total funds required for the project (sum of Columns 3 and 4) by object class category.

Separate Budget Detail Requirement

You must also submit a separate Budget Narrative/Justification as part of your application. The full Budget Narrative/Justification should be included in the application immediately following the SF-424 forms.

6. Object Class Categories--

Line 6a: Personnel: Enter total costs of salaries and wages of applicant/grantee staff. Do not include the costs of consultants; consultant costs should be included under 6h - Other. In the Budget Narrative/Justification: Identify the project director, if known. Specify the key staff, their titles, brief summary of project related duties, and the percent of their time commitments to the project in the Budget Narrative/Justification.

Line 6b: Fringe Benefits: Enter the total costs of fringe benefits unless treated as part of an approved indirect cost rate. In the Justification: Provide a break-down of amounts and percentages that comprise fringe benefit costs, such as health insurance, FICA, retirement insurance, etc.

Line 6c: Travel: Enter total costs of out-of-town travel (travel requiring per diem) for staff of the project. Do not enter costs for consultant's travel - this should be included in line 6h. In the Justification: Include the total number of trips, destinations, purpose, length of stay, subsistence allowances and transportation costs (including mileage rates).

Line 6d: Equipment: Enter the total costs of all equipment to be acquired by the project. For all applicants, "equipment" is non-expendable tangible personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit. If the item does not meet the $5,000 threshold, include it in your budget under Supplies, line 6e. In the Justification: Equipment to be purchased with Federal funds must be justified as necessary for the conduct of the project. The equipment must be used for project-related functions; the equipment, or a reasonable facsimile, must not be otherwise available to the applicant or its sub-grantees. The justification also must contain plans for the use or disposal of the equipment after the project ends.

Line 6e: Supplies: Enter the total costs of all tangible expendable personal property (supplies) other than those included on line 6d. In the Justification: Provide general description of types of items included.

Line 6f: Contractual: Enter the total costs of all contracts, including (1) procurement contracts (except those, which belong on other lines such as equipment, supplies, etc.). Also include any contracts with organizations for the provision of technical assistance. Do not include payments to individuals or consultants on this line. In the Budget Narrative/Justification: Attach a list of contractors indicating the name of the organization, the purpose of the contract, and the estimated dollar amount. If the name of the contractor, scope of work, and estimated costs are not available or have not been negotiated, indicate when this information will be available. **Whenever the applicant intends to delegate more than 33% of a project's total budget to the contractual line item, the applicant/grantee must provide a completed copy of Section B of the SF-424A Budget Categories for each sub-contractor or sub-grantee, and separate Budget Narrative/Justification for each sub-contractor or sub-grantee for each year of potential grant funding.**

Line 6g: Construction: Leave blank since construction is not an allowable cost under this program.

Line 6h: Other: Enter the total of all other costs. Such costs, where applicable, may include, but are not limited to: insurance, medical and dental costs (i.e. for project volunteers this is different from personnel fringe benefits); non-contractual fees and travel paid directly to individual consultants; local transportation (all travel which does not require per diem is considered local travel); postage; space and equipment rentals/lease; printing and publication; computer use; training and staff development costs (i.e. registration fees). If a cost does not clearly fit under another category, and it qualifies as an allowable cost, then rest assured this is where it belongs. In the Justification: Provide a reasonable explanation for items in this category. For individual consultants, explain the nature of services provided and the relation to activities in the work plan. Describe the types of activities for staff development costs.

Line 6i: Total Direct Charges: Show the totals of Lines 6a through 6h.

Line 6j: Indirect Charges: Enter the total amount of indirect charges (costs), if any. If no indirect costs are requested, enter "none." Indirect charges may be requested if: (1) the applicant has a current indirect cost rate agreement approved by HHS or another Federal agency; or (2) the applicant is a state or local government agency.

Budget Narrative/Justification: State governments should enter the amount of indirect costs determined in accordance with HHS requirements. An applicant that will charge indirect costs to the award **must enclose a copy of the current indirect cost rate agreement.** If any sub-contractors or sub-grantees are requesting indirect costs, copies of their indirect cost agreements must also be included with the application. If the applicant organization is in the process of initially developing or renegotiating a rate, it should immediately upon notification that an award will be made, develop a tentative indirect cost rate proposal based on its most recently completed fiscal year in accordance with the principles set forth in the cognizant agency's guidelines for establishing indirect cost rates, and submit it to the cognizant agency. Applicants awaiting approval of their indirect cost proposals may also request indirect costs. It should be noted that when an indirect cost rate is requested, those costs included in the indirect cost pool should not also be charged as direct costs to the grant. Also, if the applicant is requesting a rate which is less than what is allowed under the program, the authorized representative of the applicant organization must submit a signed acknowledgement that the applicant is accepting a lower rate than allowed.

Line 6k: Total: Enter the total amounts of Lines 6i and 6j.

Line 7: Program Income: As appropriate, include the estimated amount of income, if any, you expect to be generated from this project.

Section C - Non-Federal Resources

Line 12: Enter the amounts of non-Federal resources that will be used in carrying out the proposed project, by source (Applicant; State; Other) and enter the total amount in Column (e). Keep in mind that if the cost share requirement is not met, Federal dollars may be reduced.

Section D - Forecasted Cash Needs - Not applicable.

Section E - Budget Estimate of Federal Funds Needed for Balance of the Project - Not applicable

Section F - Other Budget Information

Line 22: Indirect Charges: Enter the type of indirect rate (provisional, predetermined, final, or fixed) to be in effect during the funding period, the base to which the rate is applied (salaries/wages, modified direct total costs, etc.), and the total indirect costs. Include a copy of your current Indirect Cost Rate Agreement.

Line 23: Remarks: Provide any other comments deemed necessary.

Standard Form 424B – Assurances for Non-Construction Programs

This form contains assurances required of applicants under the discretionary funds programs administered by ONC. Please note that a duly authorized representative of the applicant organization must certify that the organization is in compliance with these assurances.

d. Certification Regarding Lobbying

This form contains certifications that are required of the applicant organization regarding lobbying. Please note that a duly authorized representative of the applicant organization must attest to the applicant's compliance with these certifications.

E. Appendix E – Conflict of Interest Certification Template

CONFLICT OF INTEREST CERTIFICATION

American Recovery and Reinvestment Act of 2009: Beacon Community Program

DHHS Office:

CFDA Number: 93.727

FOA Number:

Legal Applicant Name:

Legal Vendor Name:

My signature below certifies that, in submitting the application for the above referenced award, there are no potential, real or perceived conflicts of interest relative to the anticipated collaboration between our organization _____ and the vendor _____.

I also acknowledge my responsibility to disclose any future potential, real or perceived conflicts of interest, between our organization _____ with the vendor _____ should the attestation within this certification change in the future.

F. Appendix F – Glossary of Terms

Ambulatory Care Sensitive Condition: For the purposes of this FOA, Ambulatory Care Sensitive Conditions (ACSCs) are conditions for which good outpatient care or early intervention to prevent complications may prevent hospitalizations and/or emergency department visits (e.g., asthma, chronic obstructive lung disease, congestive heart failure, diabetes mellitus, and hypertension). Ambulatory Care Sensitive Hospitalizations and Emergency Department Visits are hospitalizations or emergency department visits by individuals with ACSCs specifically to seek care for an ASCS, and have been used as indicators of problems with access to ambulatory care or poor-quality outpatient management. AHRQ has developed the Prevention Quality Indicators (PQIs) to track hospital admission rates for 14 ACSCs. These can be found at http://www.qualityindicators.ahrq.gov/downloads/pqi/pqi_comparative_v31.pdf.

Beers criteria: Beers criteria is an expert, consensus based list of medications that are considered inappropriate when given to elderly people due to their risk of potential side effects in older persons.

Care Coordination: For the purposes of this FOA, care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies: Volume 7—Care Coordination, Structured Abstract. Publication No. 04(07)-0051-7, June 2007. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/tp/caregaptp.htm

Electronic Health Record (EHR): For purposes of this FOA "electronic health record", "certified EHR" and "certified EHR technology" have been used interchangeably to signify EHRcertified pursuant to Section 3001(c)(5) of the Public Health Service Act as added by the ARRA.

EHR Adoption: For the purposes of this FOA, EHR adoption is defined as the basic use of electronic systems to substitute for paper charts -- specifically, clinical practice systems which permit patient tracking over time; clinical notes entry; electronic access to test results; and which produce and transmit prescriptions electronically (Health Information Technology in the United States: Where We Stand, ONC and RWJF, 2008.).

Eligible Professional: For purposes of the Medicare incentive, an eligible professional is defined in Social Security Act Section 1848(o), as added by ARRA, as non hospital-based physicians, as defined in section 1861(r) of the Act , who either receive reimbursement for services under the Medicare Fee For Service (FFS) program or have an employment or contractual relationship with a qualifying Medicare Advantage (MA) organization meeting the criteria under section 1853(l)(2) of the Act; or healthcare professionals meeting the definition of "eligible professional" under section 1903(t)(3)(B) of the Act as well as the patient-volume and non-hospital-based criteria of section 1903(t)(2)(A) of the Act) and eligible hospitals (subsection (d) hospitals as defined under subsection 1886(d)(1)(B) of the Act that either receive reimbursement for services under the Medicare FFS program or are affiliated with a qualifying MA organization as described in section 1853(m)(2) of the Act; critical access hospitals (CAHs); or acute care or children's hospitals described under section 1903(t)(2)(B) of the Act).

Federally Qualified Health Center (FQHC): A type of provider organization defined by the Medicare and Medicaid statutes for organizations that provide care to underserved populations and include Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, Public Housing Primary Care Programs and some tribal clinics. FQHCs provide services in both medically underserved area and to medically underserved populations.

Health Information Exchange (HIE): For the purposes of this FOA, "Health Information Exchange" or "HIE" is used to mean the electronic movement of health-related information among organizations according to nationally recognized standards.

Health Information Technology (health IT): For the purposes of this FOA, health information technology refers to hardware, software, integrated technologies or related licenses, intellectual property, upgrades or package solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance, access, or exchange of health information.

Meaningful Use: Under the HITECH Act, an eligible professional or hospital is considered a "meaningful EHR user" if they use certified EHR technology in a manner consistent with criteria to be established by the Secretary through the rulemaking process, including but not limited to e-prescribing through an EHR, and the electronic exchange of information for the purposes of quality improvement, such as care coordination. In addition, eligible professionals and hospitals must submit clinical quality and other measures to HHS.

Pursuant to Titles 18 and 19 of the Social Security Act as amended by Title IV in Division B of ARRA, the Secretary will propose and finalize a definition for meaningful EHR use through formal notice-and-comment rulemaking by the end of FY 2010.

Patient -centric (or patient centered): For the purposes of this FOA, patient-centric/ patient centered care refers to inclusion of the patient and their family/designated support systems as an integral part of the health care team, collaborating to make decisions about their care. It requires efficient and secure information flow between all the patients' providers across all their care settings.

Qualified Electronic Health Record: As defined in Section 3000(13) of the Public Health Service Act as amended by ARRA, 'qualified electronic health record' means an electronic record of health-related information on an individual that:

(A) includes patient demographic and clinical health information, such as medical history and problem lists; and

(B) has the capacity:

i. to provide clinical decision support;

ii. to support physician order entry;

iii. to capture and query information relevant to health care quality; and

iv. to exchange electronic health information with, and integrate such information from other sources.

Registry: For the purposes of this FOA, a registry shall be defined as an electronically developed and maintained list of patients with the same chronic disease or condition that can be used at the point of care and administratively to facilitate patient recall, reminders, scheduling of planned visits, and adherence to evidence-based guidelines.

Rural: For the purposes of this FOA, all counties that are not designated as parts of Metropolitan Areas (MAs) by the (OMB) are considered rural. Yet, it is noted that large parts of many urban counties may be rural in nature. Therefore, we are permitting the designation of "Rural" areas within MAs. Census tracts with Rural Urban Commuting Area Codes (RUCA) codes 4 through 10 will be considered rural for the purposes of the Beacon Community Program. More information on RUCAs is available at http://www.ers.usda.gov/briefing/Rurality/RuralUrbanCommutingAreas/or at ftp://ftp.hrsa.gov/ruralhealth/Eligibility2005.pdf.

Standards-Based Interoperability: For the purposes of this FOA, interoperability refers to the ability of health IT systems and applications to electronically exchange healthcare information between different systems and applications. Standards-based interoperability means that this exchange is based upon existing, established standards for data, services, transportation and terminologies, so that the systems and applications can "speak the same language". This will empower providers and consumers to integrate, manage, and use health information that is consistent, accurate, and useful.

Technical Assistance: For the purposes of this FOA, technical assistance refers to the provision of advice, assistance, and/or training pertaining to the initiation, operation, or maintenance of systems.

Third party payer: For the purposes of this FOA, third party payer refers to an organization which is involved in the financing of personal health services, and which is neither the recipient nor the provider of said personal health services.

Urban: For the purposes of this FOA, Urban is the geographic area represented by counties designated as parts of Metropolitan Areas (MAs) by OMB. The current list of MAs, issued in 2003, and updates are available on the Internet at http://www.census.gov/population/www/metroareas

Vulnerable Population: The Agency for Health Care Research and Quality (AHRQ) defines vulnerable populations as those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability.

G. Appendix G – Privacy and Security Resources

American Reinvestment and ARRA References

ARRA Section D – Privacy describes improved privacy provisions and security provisions related to:

- Sec. 13402 - notification in the case of breach
- Sec. 13404 – application of privacy provisions and penalties to business associates of covered entities
- Sec. 13405 – restrictions on certain disclosures and sales of health information; accounting of certain protected health information disclosures; access to certain information in electronic format
- Sec. 13406 – conditions on certain contacts as part of health care operations
- Sec. 13407 – temporary breach notification requirement for vendors of personal health records and other non-HIPAA covered entities
- Sec. 13408 – business associate contracts required for certain entities

This list is provided to highlight examples of the ARRA privacy and security requirements. It is not intended to be comprehensive, nor definitive program guidance to recipients regarding the ARRA requirements for privacy and security. To read a full version of ARRA, click here.

Privacy Act of 1974

- 45.C.F.R. Part 5b A link to the full Privacy Act can be found at: http://www.hhs.gov/foia/privacy/index.html

HIPAA Security Rule

- 45 CFR Parts 160, 162, and 164.

H. Appendix H – Letter of Intent Content Guidelines

Applicants must submit a Letter of Intent to apply for this funding opportunity; the deadline for the Letter of Intent is January 8, 2010. This Letter of Intent is a preliminary, non-binding indication of an organization's intent to submit an application and must contain the following:

- Identification and justification of specific and measurable health systems improvement goals
- Identification of the geographical area that served by the proposed Beacon Community Program, including all applicable zip codes by Zip 5 (geographical service area should include, at minimum, a defined Hospital Referral Area (see http://www.dartmouthatlas.org), political jurisdiction, geographical border, or Metropolitan Service Area)
- Organizational Mission, Capability, and Experience
    - A cover letter signed by the designated authorized representative of the lead applicant organization, which includes the organizational mission statement.
    - Current Service Offerings: If the applicant (or any members of the applying consortium) is currently offering the services listed below, indicate whether the service is currently offered (Y/N), which organization is providing it, the number of Full-Time Equivalent (FTE) staff dedicated to each, and the number of practices and providers served in the 12 month interval: July 1, 2008 to June 30, 2009.
        - EHR adoption and meaningful use assistance
        - Functional, Standards-based Health Information Exchange
        - Technical Assistance around Federal and State Privacy and Security requirements
- Ability/Intent to leverage existing programs and resources
    - Federal and ONC opportunities: Intent to collaborate with other ONC/Federal grant-funded programs (Regional Extension Center, VA, DoD, including VLER; IHS, HRSA, CMS demonstrations, Medicare Quality Improvement Organization, other)
    - Multi-stakeholder and Community Commitment: Indicate the Beacon Community's intent to involve community organizations by providing a table with the names of community partners in each of the following categories:
        - State Primary Care Association(s)
        - Health Professional Societies

- Health Center Controlled Networks (HCCNs)
  (for more information about HCCNs, go to:
  http://www.hrsa.gov/healthit/healthcenternetworks/default.htm)
- Health Plans
- Hospital Systems
- Local and State Public Health Departments
- Academic Institutions
- Charitable Foundations
- Quality Improvement Organizations

I. Appendix I – Template for Stakeholder Summary Matrix

A. Name of Stakeholder Organization	B. Name of Primary Point of Contact	C. E-mail Address	D. Type of Stakeholder Organization	E. Level of Commitment (1-4)

Instructions for completing Appendix J, "Stakeholder Summary Matrix":

A. List the complete legal name of the stakeholder organization.

B. List the name of the individual who will serve as the stakeholder organization's primary point of contact.

C. Provide the e-mail address for the individual referenced in Column B.

D. List type of stakeholder organization. This may include, but is not limited to: primary care providers (PCPs), practicing clinicians, hospitals, public and private payers, consumers, local and state public health departments, safety net providers, employers, academic institutions, charitable foundations, industry, laboratories, pharmacies, employers, quality improvement organizations, hospital associations, government entities, and medical societies.

E. Indicate the Level of Commitment (1-4) secured from each Stakeholder group using the following scale:

1 – Applicant has provided Letter of Support from Stakeholder detailing the nature of involvement with the Beacon Community.

2 – Applicant has provided Letter of Support from Stakeholder as above, and Budget Narrative for Beacon Community reflects financial commitment from the Stakeholder.

3 – Applicant has provided Letter of Support from Stakeholder as above, and Organizational Capability Statement includes board-level, specific commitment of staff to the Beacon Community leadership team.

4 – Applicant has provided Letter of Support from Stakeholder as above, Budget Narrative for Beacon Community reflects financial commitment from Stakeholder, and Organizational Capability Statement includes specific commitment of senior level executives to the Beacon Community leadership team.

J. Appendix J – Required Documents for Beacon Community Applications

- Letter of Intent to Apply (See Appendix H Letter of Intent Content Guidelines)
- DUNS Number
- Proof of non-profit status
- Project Abstract
- Project Narrative
    - Current State and Gap Analysis of EHR Adoption and Meaningful Use
    - Goals and Objectives
    - Proposed Strategy
    - Populations with Specific Needs
    - Project Management
    - Core Performance Measures
    - Evaluation
    - Coordination and Continual Improvement
    - Organizational Capability Statement
- Sustainability Plan
- Collaborations and Letters of Commitment from Key Participating Organizations and Agencies
    - Narrative
    - Letters of Support
    - Stakeholder Summary Matrix
- Nondiscrimination and Conflict of Interest Policies
- Budget Narrative/Justification
    - Application for Federal Assistance SF 424
    - Budget Information for Non-Construction Programs SF-424A
    - Project Abstract
    - Project/Performance Site Location(s)
    - Project Narrative Attachment Form
    - Budget Narrative Attachment Form
    - Assurances for Non-Construction Programs SF-424B
    - Grants.gov Lobbying Form

- Disclosure of Lobbying Activities SF-LLL